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AMERICAN POSTAL WORKERS UNION HEALTH BENEFITS PROGRAM

HEARING
BEFORE THE
SUBCOMMITTEE ON CIVIL SERVICE,
POST OFFICE, AND GENERAL SERVICES
OF THE
COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
NINETY-SEVENTH CONGRESS
FIRST SESSION

OCTOBER 19, 1981

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AMERICAN POSTAL WORKERS UNION HEALTH BENEFITS PROGRAM

MONDAY, OCTOBER 19, 1981

U.S. SENATE,
SUBCOMMITTEE ON CIVIL SERVICE,
POST OFFICE, AND GENERAL SERVICES,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 3302, Dirksen Senate Office Building, Hon. Ted Stevens (chairman of the subcommittee) presiding.

Present: Senators Stevens and Pryor.

Also present: Representatives Edward Derwinski and Steny Hoyer.

Staff present: Wayne A. Schley, staff director; Jamie Cowen, chief counsel; Pat Halcomb, chief clerk; and J. Knox Walkup, minority staff director.

OPENING STATEMENT OF SENATOR STEVENS

Senator STEVENS. Good morning, Mr. Devine, happy to have you and your staff here.

We are holding a hearing on the status of Federal employee benefit negotiations between the Office of Personnel Management and the American Postal Workers Union.

The Federal Employee Health Benefit Program is designed to provide a wide variety of health care options to Federal and postal employees.

There are approximately 120 health care carriers in the Federal Employee Health Benefit Program. Every year, beginning in the spring, the carriers negotiate with OPM for benefits and premiums. On the average, the Government covers 60 percent of the premiums.

The actual Government-employee contribution ratio, however, is fairly complex.

By law, OPM averages the subscription prices of six plans. These six plans are the Blue Cross-Blue Shield plan, the Aetna plan, the two largest employee organization plans, and the two largest health maintenance organization plans.

After the average price is determined, a fixed dollar Government payment is established by taking 60 percent of that average. That fixed dollar figure is then applied to all of the FEHB plans. Thus, the percentage the Government contributes to an individual plan's total premium varies according to the amount of the total premi-

um. It can never, however, exceed 75 percent of any plan's total premium.

The American Postal Workers Union is the largest employee organization plan and thus is one of the so-called Big Six plans. The union has been negotiating with OPM, as other plans have, over benefits and premiums.

An agreement has not been reached. Due to the imminency of the open season, the negotiations must be concluded within a day or so.

The involvement of this committee is twofold. One, this subcommittee and the House committee have oversight over the Federal Employee Health Benefit Program and are responsible for its welfare from a legislative point of view. Two, there is currently consideration being given to emergency legislation to remove the APWU health plan from the so-called Big Six. And I might add that unless we have an agreement from all parties, particularly from the other unions, a quick legislative solution would be impossible. I do hope, however, that we can get a final solution to this problem today, at least before the timeframe that is necessary to go into the open season.

Mr. Devine, I am pleased you are here today and I appreciate the manner in which you have kept us, this subcommittee and, again, the House committee, informed of the negotiations. There may be Members from the House coming. And if they come, we would ask them to join me at the committee table and we will reserve a place in the record for their statements if they decide to make any.

Mr. Devine, do you have a statement?

TESTIMONY OF DONALD J. DEVINE, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, ACCOMPANIED BY JAMES W. MORRISON, JR., ASSOCIATE DIRECTOR FOR COMPENSATION, AND JOSEPH A. MORRIS, GENERAL COUNSEL

Mr. DEVINE. Yes, Senator.

Thank you for inviting me to appear today and to discuss the Federal Employee Health Benefit [FEHB] Program.

I am accompanied today by OPM's General Counsel, Joseph Morris, and my associate director for compensation, James Morrison.

I am accompanied especially by the General Counsel today because I am under some restraints in this process. No. 1, we are involved in a court suit. We are under certain restrictions which I will mention later. There are also certain restrictions on me under common law negotiating principles, too. So I will try to be as open as I can, given those restrictions.

I would like to put a few things in the record about the Federal Employee Health Benefits Program. The program basically offers three basic types of plans. The first type is the Government-wide plans open to all employees. There are two plans in this category, Blue Cross and Blue Shield, and the Indemnity Benefit Plan offered by Aetna.

The second type is the employee organization plans. There are 19 in this category. I might mention that usually the 18th and 19th is the Central Intelligence Agency and that usually doesn't get public.

These employee organization plans are open to members of the sponsoring organizations and in many cases associate memberships are offered. It is very important to note that employee organizations participate in the FEHB program, not as labor unions, but as insurance companies and that is the relationship that I have with them in FEHB. This is especially the case with the postal unions where a relationship with those unions in my capacity as Government-wide labor-management relations officer is very limited. We are dealing with the unions in their capacity as managers of insurance plans, not as unions.

The third type of plan is the comprehensive prepayment medical plans generally known as health maintenance organizations.

One of the key elements in the success of the FEHB program has been its use of competition among carriers to encourage improvement of benefits while at the same time holding down costs. The carriers are very much aware of the need to make their plans competitive at an attractive price, and to administer their claims efficiently.

OPM has overall responsibility for administering the FEHB program including planning and controlling the fiscal operations.

Today's hearing seems to be focused primarily on OPM's effort to contain the costs of the Government's payments to the FEHB program. Let me briefly describe OPM's statutory relationship with FEHB carriers, the annual negotiation process, the basis for budgetary projections, and the formula for calculating the Government contributions.

Pursuant to 5 U.S.C. 8902, OPM is authorized by Congress to contract on a continuing basis with qualified insurers for the provision of health benefits plans for Federal employees and annuitants. The authority conferred by section 8902 provides for contracts which "shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party."

Under this authority, OPM has long maintained contracts for health benefits for employees and annuitants. As contemplated and authorized by Congress, these contracts are in force on a calendar-year basis, with annual automatic renewals. The calendar-year basis of the contracts contrasted with the fiscal year budgeting and costing process is significant because I believe this phenomenon alone accounts for some of the confusion.

While the Government's share of health premiums for active employees is paid by the several employing agencies, the Federal share of health benefit contributions for annuitants is paid from funds annually appropriated by Congress to OPM for that purpose, and maintained in a separate payment account established pursuant to 5 U.S.C. 8906(g). The amount appropriated is based on estimates by OPM of premium rates, enrollment patterns, and the number of annuitants who are expected to receive benefits during the fiscal year in question.

Each year in the spring, OPM issues a call letter to carriers asking that they propose benefits for the following calendar year. This letter informs each carrier of the deadline for their proposals and provides general policy guidance on benefit changes.

Before I describe what has happened in this year's round of negotiations thus far, I think it would be helpful to describe the formula by which the Government contribution is calculated. The rate of this contribution is determined by the average high option premiums of the two Government-wide plans, the two largest employee organization plans and the two largest health maintenance organizations, calculated on a simple arithmetic basis (unweighted).

Once this average is determined, the maximum Government contribution is fixed at 60 percent of the average or 75 percent of the cost of any specific plan, whichever is less.

Now, I would like to return to this year. When OPM staff received the responses to the March 1981 call letter, they reviewed the proposals and after consultation with the carriers, reached tentative conclusions as to the benefits to be offered in calendar year 1982. Final decision on benefits cannot be made at this point since it is necessary to first have an idea of what benefits will be offered before we can begin the process of actuarially pricing out the costs of the benefits. That allows us to determine a premium rate.

The problem we are addressing today was first recognized when I reviewed the insurance carriers' estimates for next year's program.

As I reviewed these data, it became obvious that to maintain the proposed level of health coverage would require an increase in insurance rates during 1982 of more than 30 percent in the six largest plans. Because the Federal Government pays 60 percent of the premiums for employees, the cost implications would be immense: continuing the projected level of benefits would increase the Government's share of fiscal year 1982 program costs by almost \$500 million above the amount in the President's budget and the amount passed in the continuing resolution.

Original budget projections assumed increased costs in 1982 of slightly over 10 percent. That is for the Government. It also became clear that, in addition to underestimating the effects of inflation, the prior administration seriously underpriced most of the FEHB plans in 1980 and 1981. An artificial depression of premiums for a third consecutive year would only exacerbate problems which must be faced in the 1983 budget, as well as threaten the financial underpinnings of the FEHB program.

In August 1981, I ordered an intensive evaluation of the 1982 FEHB program in light of the evolving fiscal year 1982 budget information. Accordingly, OPM returned to the bargaining table with all insurance carriers, and asked for the implementation of a series of cost-cutting measures. All insurance carriers were asked to reduce benefits, increase co-insurance requirements, and increase deductibles on an equivalency basis.

All carriers were asked to transmit their new proposals to OPM during the first week in September.

There followed several weeks of one-on-one negotiations between OPM and the carriers. The early September target date came and went without the carriers and OPM being able to reach even the threshold of agreement on a final package. It was at this stage that OPM began giving consideration to alternative benefit reductions. Among these specifically considered for exclusion or limitation were abortions, mental care, and dental care.

Practical deadlines were fast approaching. If a decision on open season were to be made at a reasonable time and if plan brochures were to be printed in time to provide useful information to the Federal work force and annuitant community, benefit negotiations would have to be concluded. Accordingly, well over a month after OPM began its intensive process of bargaining with the carriers over cost reductions, OPM set a deadline of September 25, 1981, for receipt of the carriers' last and best offers.

It is my understanding that every carrier met the deadline with the exception of the APWU. I am told that, earlier in the day of September 25, 1981, a representative of APWU informed my staff that APWU found cost reductions impossible to achieve, and therefore intended to ignore the new call for last and best offers and to stand on the offer that had already been rejected. This was confirmed to me personally in a telephone conversation with the head of the APWU plan. APWU thereafter brought suit against me, challenging not only my imposition of the deadline, but also contending that APWU's earlier exchange with OPM of first-round benefits proposals constituted a binding agreement for 1982 for FEHB purposes. The arguments by APWU have been preliminarily rejected by the U.S. District Court for the District of Columbia which has refused the injunctions sought against me by APWU and, on similar theories, by the National Association of Letter Carriers. The only directive given to me by the court is a protective order requiring me to refrain from disclosing the information that I possess regarding the financial health of APWU's FEHB plan. Because of pendency of the APWU and NALC lawsuits and because of the order, entered by the court to protect APWU from disclosure of adverse information, I have been advised by counsel to say nothing further with respect to APWU save the following: My intentions are not punitive and my actions are not arbitrary; my counsel and I have continued settlement discussions with the president of APWU and his counsel, in the hope that, even at this late hour, avenues can be found to continue APWU's participation in the FEHB program; and that those settlement negotiations, if they are to bear any fruit, must proceed privately in order to protect the legitimate bargaining and competitive interests of all parties.

Clearly, several aspects of the FEHB program are ripe for reform. I have already instructed my staff to review completely and improve our systems for actuarial and budget projections and for financial management.

From an internal perspective, this course of action is virtually all that is currently available to me.

An external reform that is crucial to the future fiscal integrity of the FEHB program would be to end the triggering provisions of the statute which automatically include the two employee organization plans with the largest enrollments in the Big Six for rate computation purposes.

The interests of both the Government and its employees and annuitants would be better served if OPM were given discretion to choose two out of the four employee organization plans with the largest enrollments for this purpose.

OPM's discretion would be based, in each instance, on the totality of the circumstances—looking not only to the number of enrollees, but also to program costs, benefits distribution, representativeness, and each carrier's financial and managerial soundness.

Such a discretionary provision would also have the advantage of giving a large employee organization carrier something akin to probationary status within the FEHB program during a time of financial and managerial stress. It could continue within the program, and work out its internal problems, without having those problems affect costs and price realities for everyone else.

I believe you will agree that we are faced with a real dilemma for which there are no easy answers. To protect the Government employee, it is necessary to keep premiums under control and to maintain benefits at an acceptable level. To protect the taxpayer, it is necessary to keep the Government contribution within budget constraints. The only solution is to pare benefits this year, and to do so to the extent necessary to protect the budget, the financial integrity of the FEHB, and the separate insurance plans.

That ends my formal statement. I will be happy to answer any questions you may have but I would like to, again, remind you I cannot comment on the internal financial picture of the APWU plan. And since I am also still in the process of negotiations, I will be somewhat restricted there. But I will try to answer any questions to the best of my ability to do so.

Senator STEVENS. We have a statement here from Congressman Derwinski which I want to print in the record.

[The statement of Congressman Derwinski follows:]

OPENING STATEMENT OF HON. EDWARD J. DERWINSKI

Mr. Chairman, we are here today to look into the complex problem of the federal employees health benefit plans, and to try to work out a reasonable and equitable solution to serve all federal employees.

The Director of OPM, Dr. Devine, is engaged in a difficult task of re-negotiating premium rates for the numerous federal employee health plans, while restricted by the budgetary goals set by the Office of Management and Budget. The task of balancing the quality of health benefits along with some cost savings is a difficult and highly technical exercise. The witnesses testifying today will hopefully shed some light on the problem or may even come up with some solution to the dilemma.

A special problem facing us now is the timeframe set for the open season. The open season has already been delayed one month, and every day that goes by without a solution serves only to add to the confusion facing federal employees, and endangers the system itself.

The other issue is the wisdom of allowing Congress to get involved via a legislative solution. With the variety of views regarding the FEHBP's, an emergency legislative effort could be a futile exercise without true unanimity from all the Federal union plans. Without unified support legislation will go nowhere. Nothing can come of quick-fix solutions with a disparity of views and any patchwork job will only serve to complicate matters in the future.

As the ranking minority member of the House Post Office and Civil Service Committee, I stand ready to co-operate in any practical solution.

Senator STEVENS. I am happy Congressman Hoyer is here this morning.

Let's get right to the matter of this court order to start with. I have been a lawyer for 30 years. Are you telling me the court has enjoined you that you cannot answer my questions as chairman of this subcommittee? If that is the case, I would like to see the order. I can't believe that a court would tell you or your counsel that you cannot respond to legitimate questions from a Member of Congress.

I want to get that straightened out first, Mr. Devine. They can tell you if they want that you cannot disclose information that has been provided to you by APWU concerning the soundness of that organization. If that is the scope of what has been told you, fine. If it goes beyond that, then perhaps we will have to subpoena the district judge and see what he intended in his court order, because I know what Congress jurisdiction is and it is to try and find a legislative solution if at all possible to prevent this union from going out of business.

I want to get the ground rules laid here first before I start asking questions because I don't want to go through this morning and have you say I'm sorry, I can't answer that. Which one of these gentlemen is your general counsel? What is the scope of this injunction as far as this committee is concerned?

Mr. MORRIS. Mr. Chairman, this is a protective order, not an injunctive order, entered by Judge Pratt of the U.S. District Court for the District of Columbia. It was entered from the bench at the hearing on the temporary restraining order sought by APWU in its lawsuit against Director Devine. It was entered on the motion of APWU and it directed the defendants in that lawsuit to refrain from disclosing information that they might have about the financial position of APWU in preparing its bargaining position. Specifically referred in that order are the submissions of those data possessed by OPM to the court in the context of that lawsuit.

Senator STEVENS. And it covers those things which adversely affect the position of the APWU?

Mr. MORRIS. The internal financial condition.

Senator STEVENS. Did it refer to Congress at all?

Mr. MORRIS. No, Mr. Chairman, it did not.

Senator STEVENS. I take it you are in position to advise Mr. Devine if his answers to any specific questions might violate that order. As I understand also, it was presented by APWU.

Mr. MORRIS. My advice to Director Devine is that when he is asked to make public, outside the context of that lawsuit or settlement negotiations with APWU, information relating to the internal financial position of the health plan, the court has directed him not to do so. He is free under the terms of that order to respond to any other question in any public setting relating to the FEHB program and to the APWU health plan's participation in it.

Senator STEVENS. Just so we understand it. I misunderstood the scope of the order as Mr. Devine made his statement. There is no use having a hearing if the court is going to tell us that you can't answer the questions. I don't think they or any court would do that.

Mr. Devine, so we can get the background of this, again, I know there is some information you may not have with you in terms of the precise dollar amounts, but just generally, I need to have on the record here, so we can explain this to others in the Senate who are interested, what are the financial problems, the financial objectives concerning this year's negotiations process? Prior to commencement of this process, as I understand it, you were instructed to hold to a specific dollar limit as far as the program is concerned, is that right? This is an OMB directive?

Mr. DEVINE. No, Senator. My only limits are the limits that were passed by Congress when they passed the continuing resolution—

Senator STEVENS. You said that once before. I was the negotiator for the Senate on the continuing resolution. There is no dollar limit in it. It is the 1982 figure we adopted for the continuing resolution.

Mr. DEVINE. It is my understanding that the \$792,754,000 is referenced in the continuing resolution as a limit on what we can pay for the Government's share of annuitant benefits. Is that not so?

Senator STEVENS. We will check that. If they incorporate another provision in another section we were not dealing with, it could have happened. I don't think it is that specific. We will check with the other committee to see if there was something in that jurisdiction. As far as the continuing resolution is concerned, I was part of the negotiation. We took the 1981 figure, that is the appropriations process took the 1981 figure for the continuing resolution. The continuing resolution runs out November 20. We are not talking about the same thing.

Mr. DEVINE. As I understood the continuing resolution, continuing activities in lieu of the permanent appropriations bills, it allowed us to make our spending decision based on that figure. It is that figure which moves everything else in terms of this negotiating process.

Senator STEVENS. Let's just assume that is the figure. How does that differ from the cost of the program in 1981?

Mr. DEVINE. If I could, I would like to go a little further with that figure. These figures appear in the appendix to the budget on page I-V 115. The \$792,754,000 is the budget authority appropriation figure which is arrived at by going through an account. This account starts with Government contributions for annuitants—based in law—of \$823,946,000. It goes through several offsetting figures including a \$40 million figure which was supposed to be carried forward from the previous year's budget which, in fact, was not there. In any event, the bottomline figure comes up to that \$792,754,000 figure. But that figure itself refers back—

Senator STEVENS. Wait a minute. I want to get some frame of reference. What was that figure for 1981? That is fiscal 1982.

Mr. DEVINE. The 1981 estimate I have is \$757,617,000.

Senator STEVENS. All right. Go ahead, I am sorry. I didn't mean to interrupt.

Mr. DEVINE. That also refers back to the figure in the appendix at page I-V 119 which is \$823,946,000. The figure that begins the table that I just referred to is part of that table.

This table on page I-V 119 is the full accounting figure, the budget figure for the Government's employees health benefit fund. There is in that figure for the 1982 estimate, the \$4,519,107,000 figure, which is the beginning figure of payments to carriers. This gives us the basic scope of the program.

You carry down these figures and you find that what is included here is a financing subtable. The financing comes from Federal funds of which \$1,421,654,000 comes from agency contributions; \$823,946,000 comes from Government payments for annuitants.

This figure less those offsets comes down to the \$792 million figure, and then there is interest and employees' payments and so forth.

Senator STEVENS. Now are you trying to achieve savings lower than the \$792 million now?

Mr. DEVINE. No, sir, I am not.

Senator STEVENS. With regard to these negotiations, what is the status of your target as far as the plan is concerned? In other words, if all of the plans come in as you now envision them, plus the APWU coming in at the low option, would you reach the target of \$792 million?

Mr. DEVINE. I would reach—well, I think before I answer that I have to put it in the other context. That is why I referred to the other table. You can't just put in the \$792 some-odd million. You also have to put in the agency contributions. Because it is the sum of them that makes up the total Government payment. If you add those two together, the total Government contribution is \$2,246,000,000.

Senator STEVENS. \$2,246,000,000?

Mr. DEVINE. Again, that is right out of the budget and, again, as I understand it, all of that is carried forward in the continuing resolution. If we had gone ahead with the benefits that the carriers suggested, the Government total would have been \$2,690,000,000. Therefore, if I had gone ahead with the original benefits proposals that the carriers requested, I would have spent \$444 million—that is the roughly \$500 million figure that I mentioned—I would have spent \$444 million more of the taxpayers' money than Congress or the President authorized me to spend.

To answer your question directly, with the present benefits and the other administrative decisions we have made to reduce costs, and if APWU accepted a low option plan that we outlined to them, we would meet the constraints for Government contributions under the law, which is the continuing resolution. However, even then I would have to go back to Congress for a supplemental appropriation in 1982 of \$136 million.

Senator STEVENS. Why would you have to do that? Those are not your responsibilities. Aren't they the agency responsibilities? The line item.

Mr. DEVINE. No; the problem is that the previous administration underestimated the number of annuitants and overestimated the number of contributions from the agency. The shortfall comes out of OPM's annuitant account. So I have to go back and ask for the supplemental appropriation for the annuitant account. Also there is \$58 million we discussed before which is a carryover from 1981. Even with benefit reductions, even with the APWU plan accepting the low option, I am still going to have to go back to you outside of the President's budget, outside of what you have recommended, for a supplemental appropriation of \$194 million.

I am not at all cutting back to the President's program. I am, in fact, even with all the changes I have made, going to have to ask for a very substantial supplemental appropriation.

As I said in my statement, and as I have told you and everyone else I have talked to on this matter, I have gone about this in the most responsible, most conservative way possible to cut back as few benefits as is humanly possible to do under the constraints in the

continuing resolution, as I understand it. Even after all that, I am still going to have to go back to OMB and come back to the Senate and to the House to ask for a supplemental appropriation of \$194 million.

Senator STEVENS. \$194 million?

Mr. DEVINE. Yes, sir.

Senator STEVENS. How much of that comes out of the APWU under current low option proposal?

Mr. DEVINE. None of that comes out of anyone. This would be a supplemental appropriation from the taxpayers —

Senator STEVENS. I understand that. What is attributable to the APWU negotiations if you go on the low option basis that you suggested?

Mr. DEVINE. None is attributable to APWU. This is attributable to everybody. APWU, in my opinion, if it accepted the low option plan, would be meeting its responsibilities to get the overall plan within the constraints that were set for me by Congress as I understand them.

Senator STEVENS. Where are you in these negotiations if you take out the APWU, how close have you come to the target of \$2,246,000,000?

Mr. DEVINE. If APWU is not part of the plan?

Senator STEVENS. Just leaving it aside for the time being, assuming that you could keep APWU within the area that you had envisioned for it, can you separate it out so you can tell us with regard to all the other plans, are they within the target?

Mr. DEVINE. If they accept the low option plan?

Senator STEVENS. If the APWU accepts the low option plan, does it have any effect on the others?

Mr. DEVINE. It would reduce the Government payment and, therefore, increase everyone's premium. However, that is going to be the net result no matter what happens. I don't intend to violate the restrictions Congress put on me. If APWU does not accept the low option plan, then we are going to go back and renegotiate all benefits and all benefits will be reduced by the degree it takes to arrive at that savings figure.

Senator STEVENS. Where did the estimate of \$792 million come from and the total estimate of \$2,246,000,000? Did that come from your agency?

Mr. DEVINE. Yes, before I was there, but it came from my agency.

Senator STEVENS. I don't mean to be offensive, but has that been rechecked? We had a series of errors come out of that agency recently. Has that been rechecked?

Mr. DEVINE. Sir, I sympathize very much with what you say. I sent them back 10, 20, 30 times to recalculate this. I think I finally have the right figures.

Senator STEVENS. Are the ones we are talking about now the \$2,246,000,000?

Mr. DEVINE. The \$2,246,000,000 appears to be quite straightforward since it is in the budget.

Senator STEVENS. But they came from your shop originally. Are they correct as far as continuing the level of benefits that exist? At

the time that was negotiated, no one told us we were going to have to reduce benefits.

Mr. DEVINE. That is correct.

Senator STEVENS. What would be the level of appropriations to continue into 1982 those benefits that existed in 1981? I thought that was what it was.

Mr. DEVINE. Again, I don't know what the cost would be to continue the precise level of benefits for 1982. The reference point I have is what the carriers wanted to go forward with in 1982, which is somewhat more than 1981, but not very much more because the initial instructions that went out to them were to keep roughly at the same benefits of 1981. That would be \$2.69 billion, the amount I gave you.

Senator STEVENS. \$2.69 or \$2.246 billion?

Mr. DEVINE. \$2.246 billion is what is in the budget; \$2.69 billion would roughly be the amount to keep at the 1981 benefit level. Again, there would be some shifts back and forth. We did tell them to carry it at about the same level as 1981. So one could say that \$2.69 billion would be approximately the amount that would be needed to keep benefits at the 1981 level.

Senator STEVENS. I recall getting involved with this at the time of the continuing resolution. Congressman Derwinski is here. I think he was there when Congressman Ford and I mentioned it briefly. We didn't think there was a problem since the agreement was we would continue the benefit level for 1981 into 1982, no expansions, no reductions. Isn't that right? Wasn't that the budget figure?

Mr. DEVINE. That is what was based on the estimate of what increased costs would be at that time. Costs have since increased very substantially, more than the OPM estimates expected them to.

Senator STEVENS. I understand that. The intention was we would just hold the line on benefits, no reductions, no expansions of benefits in terms of the Federal employee health benefits, is that correct? It was involved peripherally in the reconciliation changes. You will recall, there was an attempt to take some money out of this account. We got into it rather deeply to see whether that account could stand taking that money out of it. And when we discovered it could not, we prevented that.

As a matter of fact, there was a close vote on the floor of the Senate. I think we only won by two or three votes. Everyone agreed to continue the level of benefits from 1981 to 1982. My understanding of what you just said, you agree that was our intention but when you looked into the money, the carriers came in with estimates to achieve that which were much higher than anticipated, is that right?

Mr. DEVINE. Yes, sir.

Senator STEVENS. That is the difference between \$2.246 billion and \$2.690 billion, is that right?

Mr. DEVINE. Yes.

Senator STEVENS. Again now to quantify this, if APWU is dropped from the Big Six and replaced by the next highest plan, what is the dollar figure that is attributable to that action? Just

one in, one out. What is the dollar figure attributable to that action? Can you estimate that?

Mr. DEVINE. About \$120 million.

Senator STEVENS. Which plan would that be that would go?

Mr. DEVINE. Our best estimate is that it would be the Mail Handlers plan.

Senator STEVENS. As I understand your previous testimony, even if there is a substitute, you are going to have to come in for how much?

Mr. DEVINE. \$194 million.

Senator STEVENS. If my fast calculation is right, you are \$30 million off on a program that costs \$2.69 billion, is that right? You know that OMB tells me if it is less than \$50 million forget about it. If it is more than \$50 million, make it \$100 million. Round it off to \$100 million. Remember what Dirksen said, when you start talking about millions, you get lost.

Mr. DEVINE. I don't understand how you get the \$30 million.

Senator STEVENS. You say you are going to have to come in with \$120 million.

Mr. DEVINE. \$194 million.

Senator STEVENS. Your difference is \$120 million. You are looking for \$450 million.

Mr. DEVINE. The \$444 million, roughly \$450 million, is additional to the \$194 million. So we need to go to the full benefits at the 1982 level, we would need \$444 million and \$194 million. It is not a subtraction; an addition.

Mr. HOYER. Could you repeat that, Mr. Chairman.

Senator STEVENS. Yes; Congressman Hoyer would like to make sure we all understand that. You are saying that the \$120 million that would be saved by dropping the APWU from the Big Six—

Mr. DEVINE. Dropping APWU has nothing to do with the needed supplemental.

Senator STEVENS. It has nothing to do with the supplemental of the \$194 million, right?

Mr. DEVINE. Yes, sir.

Senator STEVENS. You suggested two in and two out. How does that qualify?

Mr. DEVINE. Two in and two out gets us even with the budget overall for Government contributions. It would still necessitate a \$194 million supplemental appropriation to put the required amount in the payment account for annuitants. As you know, the amount shown in the budget for agency contributions is really not an account. It is shown as an off account in the budget, but it is simply an estimate of percentage of payroll.

Senator STEVENS. I think the confusion that is coming here is that you mentioned \$2,246,000,000 as being the original budget item. \$2,690,000,000 is the cost the carriers have given you, right?

Mr. DEVINE. Yes, sir.

Senator STEVENS. The \$194 million is the cost to carry the, what, the \$2,690,000,000 through the agencies?

Mr. DEVINE. The \$194 million is made up of two elements. First, \$58 million, which is the shortfall in 1981. Second, \$136 million which, in effect, we have to take out of the agency contribution and put into the annuitant contribution. The reason you need a supple-

mental for it is the agency contribution is not a line item in the budget; it is simply an estimate that is made by OPM to put in the budget so we can estimate the costs of the program.

Our calculations of the distribution of enrollees between employees and annuitants show that that figure has been off and now we need a supplemental appropriation to make up that difference. In a sense, it could be seen as taken out of the agency's budget but, since it is not specifically appropriated into the agency budget, it is necessary to get an appropriation to put it in the annuitants' account where it belongs.

Senator STEVENS. With two in and two out, you indicate there would still have to be some premium changes as far as the plans are concerned.

Mr. DEVINE. Well, again, it depends. We have not made any estimates to the world, so to speak, for the 1982 premiums. Certainly it means an increase in employee contributions relative to what was originally estimated.

Everything else in a sense is hypothetical. The employee contributions under the budget should be \$1.82 billion but for the present package which would assume a low benefit option for APWU's plan, it would be \$2.21 billion.

Senator STEVENS. \$390 million difference?

Mr. DEVINE. I think so. But, again, sir—

Senator STEVENS. What did the 4.8 pay increase cost the Government? That is more than the pay increase cost. I would like to compare that when we are through. That is just sort of an aside.

The difficulty we have is this: As I understand it, the low option plan that has been suggested for the APWU still would not meet the financial objectives, is that correct?

Mr. DEVINE. It still would not?

Senator STEVENS. Is that my understanding of what you just said?

Mr. DEVINE. It would meet the budget, as I understand it, but, again, it would need the supplemental appropriation which I see as basically a shift between agency accounts and the annuitant account. In a sense, one could argue that I should be including that \$194 million into the benefit adjustments, too. That is why I say I am taking a conservative approach in terms of employee contributions and Government contributions.

I would suspect OMB might have some difficulty with this conservative approach I am taking because one certainly could argue that that \$194 million should be included in the benefit reductions also. But I have tried to take this at the minimum level of problem and disruptions to employees in the Government as I can.

Senator STEVENS. Again, and I am sure the other gentlemen may have some questions, so I understand this now—let's put it this way: Do you oppose just taking the APWU out and letting the next largest go into the Big Six as a solution for the problem?

Mr. DEVINE. If that were done, I would reopen negotiations with all carriers to achieve the amount of money needed to come into accord with the budget, as I understand it.

Senator STEVENS. I don't quite understand the way you do it for \$120 million and not going to do it for \$194 million. Why don't you

do it for the \$194 million if you are going to do it for the \$120 million?

Mr. DEVINE. Because I view it, and, again, I can certainly be criticized for it, but I view that as a transfer from the agency contribution to the annuitant's account.

Senator STEVENS. You mean you don't think that is an increase in the budget?

Mr. DEVINE. It is an increase in the budget in one sense because I have to ask for a supplemental. But if I understand this budget summary table that I mentioned, it says that the total Government contribution shall be \$2.246 billion. Therefore, I believe that I can work with that figure as a total Government contribution.

Certainly, if it is the will of the Congress to include the \$194 million within the package, I will be willing to do that. I just think that is too disruptive and, again, I certainly expect I will receive some argument from OMB on that.

Senator STEVENS. You are basically asking then, now, that APWU accept the low option plan to replace their current plan. On the basis of the benefits of that plan, what is the major difference? What is the difference in the deductible, for instance?

Mr. DEVINE. It is a very major restructuring of the plan. I would not say that the only purpose is to achieve a budget saving.

Although I am restricted from talking about details—

Senator STEVENS. I think we all understand it.

Mr. DEVINE. I think a low-benefit plan would help the financial position of the APWU plan itself. It would be a major change from a high option to a low option plan.

It would not be the lowest option plan offered in our FEHB program. It would be a major change in benefit offering for APWU, however.

Senator STEVENS. I remember in one of our discussions we discussed negotiations with the Postal Service. Weren't the health benefits one of the items in negotiation?

Mr. DEVINE. As I mentioned in my statement, I deal with APWU not as a union, but as a health insurance carrier. They come to me the same as Aetna or Blue Cross or any other insurance plan. I have no knowledge of their negotiations since they, by law, were conducted out of our direct supervision. I have no knowledge of what was in that negotiating package. If health benefits were part of the negotiations, it was inappropriate because APWU as a carrier is required to go into negotiations with OPM. The Postal Service can't commit OPM to any level of benefits.

Senator STEVENS. Just to summarize to make sure I understand, there are two avenues at the present time which, in your opinion, APWU could follow to achieve the objectives of the budget.

One is taking two unions in and two unions out of the Big Six which would have an effect on all other unions and the second is to accept a low option plan to replace their current plan, is that right?

Mr. DEVINE. I am not sure that is all the options. If we are going to solve the budget problem, it seems to me there are three options. APWU could accept the low option plan. Second, we could go to a legislative solution of two out of the four. Or third, we will have to go back and renegotiate benefits for all plans, not just employee

organizations, but Blue Cross-Blue Shield, Aetna, and all the carriers.

It seems to me those are the three options.

Senator STEVENS. If APWU accepts the low option plan and in the open season there was a severe exodus from their plan so that they no longer were one of the Big Six and the next largest came up automatically rather than through legislation, it just became the next largest, wouldn't that have an impact on your whole target?

Mr. DEVINE. It would for next year, but not for this year.

Senator STEVENS. For 1982 is what we are talking about.

Mr. DEVINE. For 1983.

Senator STEVENS. Why not 1982?

Mr. DEVINE. As I understand the law, it is based on this year, rather than the next year.

Senator STEVENS. It is based on the organization—

Mr. DEVINE. It is based on the current enrollment which would be the 1981 enrollment.

Senator STEVENS. But your open season is in fiscal 1982, this year, not in 1981. It is the first year you carried the open season over into the next year?

Mr. DEVINE. I know open season is set by regulation for part of November and I think part of December of each calendar year.

Senator STEVENS. It would not have any impact this year, then, that is your testimony, is that right?

Mr. DEVINE. Yes, sir.

Senator STEVENS. Mr. Derwinski, I put your statement in the record.

Representative DERWINSKI. Dr. Devine, I would like to very briefly go over some of the things Senator Stevens covered. First, you did properly note you were still conducting negotiations with APWU. I note in your statement that you indicated out of necessity that this was handled privately. I don't want to press you to the point where you would be getting into something that you cannot in an open session indicate. We understand that.

At the risk of oversimplification, is the real problem one that a proposal that would seem to be in the best interests of the APWU might then, in fact, not be in the best interests of a number of the other carriers?

Mr. DEVINE. I don't think so. If APWU accepts the low option, then we solve the budgetary problem and will proceed with an employee contribution of \$2.21 billion. If APWU does not accept any contract and another organization replaces it, I will still have to save more money and I will then go back into negotiations with all carriers again, including all employee plans, and employees will end up spending \$2.21 billion.

Or third, if there is a legislative solution of two out of the top four, employees will still pay \$2.21 billion. In my opinion, the effect on employees would be absolutely the same—unless there is a legislative outcome which would not allow me to negotiate or which would deny an increase in appropriations.

Representative DERWINSKI. Let's stay on this subject of the viability of the APWU. If the APWU would accept your low option plan, would this reduce their competitive status? What would this

do to their ability to attract a reasonable number of participants in their program?

Mr. DEVINE. This is a very difficult question to answer. I understand that APWU believes that they will not be able to compete with this kind of coverage. I don't see why that should be so. I think in an era where people are more cost-conscious, where premiums in general will rise, and where employee contributions in general will rise, the people are going to be looking for cost-efficient plans. That is precisely the plan we have suggested for APWU. I will mention that the Mail Handlers have a similar plan and they have been very successful in attracting Government employees into their plan.

They have been very successful with this kind of coverage. So I don't believe that they will not be able to compete with this plan. I recognize that shifting from a high option plan to a low option plan is a major change and it is one that will require good salesmanship and efficient management, but I think that those qualities are required by APWU regardless of what kind of plan they have.

Representative DERWINSKI. But if the APWU would accept the plan that would make it more cost effective in your judgment to meet its long-term need for viability, this would require some reduction in benefits and, therefore, a problem with its competitive status.

Mr. DEVINE. Yes; even if they weren't in the Big Six for computation purposes, we would suggest a plan that had much lower benefit coverage than they have now.

Representative DERWINSKI. Just as an aside, I notice here we are pondering the future of health benefits and you have been smoking about one cigarette every 10 minutes. The only other nervous smoker in the room I notice is Pat Nilan, puffing on a cigar. Between the two of you, you need health benefits.

Let me get to one other point that you kept responding to Senator Stevens, and that is, if we go to this supposed legislative cure so that you would have the alternative of selecting two new participants, you are telling us that this would require that you would have to reopen negotiations with all the other carriers.

Mr. DEVINE. No, sir, that solution would solve the budgetary problem. If we put aside the supplemental appropriation again, it would solve the problem, and I think we would go at it on a very orderly basis.

Representative DERWINSKI. You lost me there.

What will you have to have from the other carriers if you get this legislative adjustment you speak of?

Mr. DEVINE. Nothing; that would solve the problem. The option that wouldn't solve the problem is the two out of three solution that Senator Stevens mentioned earlier. The two out of three solution would still leave us with a very substantial shortfall and then we would have to go back and renegotiate the contracts.

Representative DERWINSKI. What is the real timeframe we are facing?

Mr. DEVINE. That is a very good question.

Frankly, as we get tossed around by the courts, the possibility of an open season itself becomes problematical. We originally intended to begin printing brochures, which is the critical process in

alerting Federal employees of changes in benefit coverage, last Thursday. Every day that we go without printing these millions of brochures, which we have to print—and we can't print them until all negotiations are closed—the possibility of an open season becomes less likely.

In a sense, if we do not address these very serious constraints, we won't have an open season.

Representative DERWINSKI. Again just to be sure I understand the situation, you have successfully negotiated with all other plans and they have all reached some agreement with you. Whether they are reluctant or not, they did reach some agreement with you?

Mr. DEVINE. That is not fully true. We are in court with some of the carriers. We have not reached even general agreements with some other carriers.

Representative DERWINSKI. I am almost afraid to ask more questions, Mr. Chairman. I yield to Mr. Hoyer.

Senator STEVENS. Mr. Hoyer, let me ask one thing because your colleague's questions stimulated this question.

What is the premium level for the Big Six now? Is it identical? All six of them are charging the same premium?

Mr. DEVINE. No, sir, they all charge very different premiums.

Senator STEVENS. Have you got that premium level? What do they charge? Blue Cross-Blue Shield must be the largest. What does it charge?

Mr. DEVINE. The current rate, for 1981 for the Blue Cross high option plan is \$28.89. The Aetna high option is \$24.40, and the American Federation of Government Employees is \$22.72. These are self-only rates and there are family rates also. I am sure you don't want all 120?

Senator STEVENS. No, just tell us about the Big Six. Is APWU the highest?

Mr. DEVINE. No, I believe Blue Cross is still the highest.

Senator STEVENS. The question that came out in my mind was why aren't you negotiating with the highest premium carrier of the largest union in order to bring about reductions?

Mr. DEVINE. It is due to the strange way the law is set. It treats all Big Six carriers as if they had the same number of people enrolled in them. It is very strange but that is what the law says.

Senator STEVENS. Wouldn't you save more money in negotiating with Blue Cross-Blue Shield?

Mr. DEVINE. We are negotiating with them and they are making very substantial cuts, but each of them is treated as if they had the same number of employees, so the relative share you get from one is the same as any other, no matter how many they have in it.

I agree that is irrational, but that is what the law says.

Senator STEVENS. I will pursue this later, Mr. Hoyer. I am sorry to interrupt you.

We do seem to have a strange problem here, why, if this union has difficulty, it ought to be singled out in negotiations to have reductions in premium contributions when there may be others that have higher numbers of people who have higher premiums who actually in effect are costing the plan more because you do average them. If you knocked off the top one in terms of averages, it would be a lot higher than if you took off one of the middle ones.

Mr. Hoyer, I will pursue it later. I didn't mean to hold you up.

Representative DERWINSKI. Just to follow up, the two factors that affect the competitive relationship of all these programs are obviously the premiums and the benefits.

I want to be sure I understand that you have negotiated with all the other plans substantial reductions in their benefits. Is that correct?

Mr. DEVINE. Yes, sir.

Representative DERWINSKI. The one remaining negotiating relationship you face is with APWU.

Mr. DEVINE. With one or two exceptions, yes.

Representative DERWINSKI. Thank you.

Mr. DEVINE. And, again, I would like to say with regard to APWU, just to keep matters legally straight, only in the court settlement context have we continued to negotiate. It is still our legal position that they did not make any offer that could be deemed acceptable during the contract negotiation period which ended September 25.

Representative HOYER. Doctor, as you know, we have been talking here about the carriers having a problem. We have been talking about some having budget problems. My own view, as we discuss this, is that the real problem is the employee. The end result is that employee benefits will be cut. We had this discussion when you last appeared before Chairman Oakar's committee.

Let me see if I can understand some of your figures. If I understand your answer to Senator Stevens' question, in the continuing resolution the \$2.246 billion figure would have presumably continued 1981 benefits, as was expected by the Congress. Is that correct?

Mr. DEVINE. Well, I think we are dealing with different people's assumptions. I think that was the assumption of Congress, as I read those discussions Senator Stevens spoke about in the Senate, but the budget was submitted with assumptions that I am not aware of as to whether they included the same level of benefits in 1981.

I just don't have knowledge of that.

Representative HOYER. I never heard in any discussions during the reconciliation process or the continuing resolution process of a reduction in benefits, and that does not mean it was not discussed. I just never heard it. Presumably Senator Stevens is absolutely correct. You mentioned on at least four or five occasions about how Congress has locked you into this figure and, therefore, these benefits have to be cut.

Senator Stevens pointed out, I think very clearly, that the only thing we locked you into was the figure that was given either by your predecessors or by yourself, a figure that would have continued benefits at the present level. Is that a fair statement?

Mr. DEVINE. I think in terms of Congress assumption, that may well be true, but I am faced with some numbers.

Representative HOYER. I understand. Thereafter, as I understand it, on the 27th you found out there was an underestimate and that the figure given to Congress was, in fact, not sufficient to meet the benefit levels. Is that correct?

Mr. DEVINE. Certainly that is part of it, but I think the fact that inflation is increasing more than was estimated originally is also

part of it, and health insurance costs increasing independent of inflation is another part. So I say that is a part of it.

Representative HOYER. Doctor, am I correct in assuming that the economic projections were incorrect; therefore, the programs will cost more. I don't care about who made a mistake.

Mr. DEVINE. Again, it is hard to say whether OMB, the President or, for that matter, the Appropriations Committees were talking about a figure of expenditures that they were interested in or a level of benefits.

Obviously, both are involved here.

Representative HOYER. Doctor, you have already indicated that. But wouldn't it be fairer when OPM transmitted a figure to the Budget Office and then to us contemplating that figure and incorporating reduction in benefits, that these facts would be made known to the Congress?

Mr. DEVINE. Yes, I think that is fair.

Representative HOYER. And in fact we have agreed that was not done.

Mr. DEVINE. Yes.

Representative HOYER. So what has happened is sometime between the transmittal of that figure and your recomputation it was determined that we simply cannot back up the present benefits with the dollars you have available. And because of this, we are going to reduce benefits or increase the employee's contribution and not ask for additional funds to fund our mistake. Am I correct?

Mr. DEVINE. That is certainly one way of looking at it.

Representative HOYER. Do you think it a fair observation that every employee who sees these effects in his paycheck will view it that way?

Mr. DEVINE. Again, putting together a budget is a very complex process. I suppose that those who receive less benefits under budget reductions would look at it that way. It is not an unfair way to look at it.

Representative HOYER. And, Doctor, I asked you this question in another hearing and would like to have it on the record in this hearing.

Am I correct that when the administration made its determination, presumably with your advice and the advice of others, that 4.8 percent was the appropriate level for an increase in pay based upon a projection of benefits and annual salary, that the present level of health benefits was factored into that projection of 4.8 percent being an appropriate level for a raise?

Mr. DEVINE. Yes, but it is important to remember that in that computation the net effect of health insurance is very small. Almost the whole effect of taking into account the total compensation comparability aspect is in regard to the retirement system.

Representative HOYER. Which included, did it not, Doctor, the twice-a-year cost of living adjustment?

Mr. DEVINE. Not in our figures, no.

Representative HOYER. You had already projected a reduction in the COLA then? Well, Doctor, let us go into more specifics. If I understand the \$194 million figure that is in effect, is the \$136 million a transfer from the budget of the agencies to the OPM budget and, therefore, is not effectively an increased cost?

Mr. DEVINE. \$136 million?

Representative HOYER. It would be a cost to OPM and not to the agencies. Am I correct?

Mr. DEVINE. Again, someone in OMB agreed with me in saying that I am increasing the budget because the employee's contribution is taken as a percent of salary in OMB's estimate. It doesn't show up as a line item.

But I would say, in referring to the full table in the off budget section of accounts on page 119, that it is a fair reading to say that there was an intention to include that \$136 million even though it was included from the agency budgets, not in a line appropriation. So I think it is fair to say that it is anticipated as a budget amount.

Representative HOYER. I am not sure I understood what that meant as far as my question. What I am asking is, I seem to understand \$136 million would otherwise be an agency expenditure and not yours. However, your proposal is that it goes from the agencies to your shop and, therefore, in terms of the budget of your shop, it is a \$136 million increase. Presumably you wouldn't have to offset a \$136 million decrease in the agency. Am I correct in saying that? Is that what you are saying?

Mr. DEVINE. No, not really. Because the agencies do not show health insurance as an item in their budget, you can't capture the \$1.42 billion—

Representative HOYER. Unless you went to the agency and in effect said, "Cut 12 percent of this figure."

Mr. DEVINE. That is what you would have to do.

Representative HOYER. And the proposal would be unknown to your administration. I understand it is not a line item figure in the agency budget. It is within their personnel cost and figures. Presumably some percentage could be attributable to these health benefit costs. The \$58 million figure in that \$194 million, I understand, is simply a shortfall. How does that shortfall result? How would you get additional premium costs in a contract?

Mr. DEVINE. Of course, this was for fiscal year 1981, and I believe it was two major parts. One was an underestimate in the number of annuitants who would retire in 1981 and the second aspect was some errors in projection of payment levels.

Representative HOYER. Doctor, and again, you are more familiar with the Federal budget process than I am, but in 12 years of Maryland State Legislature, it was normal practice that there would be shortfalls in programs and at the beginning of the fiscal year you would come in with a supplemental appropriation to cover this. So the \$58 million would be a normal—I don't know anything about its history—but it would be fair to say that is a normal kind of thing to occur?

Mr. DEVINE. This should have come in in a supplemental at the end of 1981, calendar year 1981.

Representative HOYER. So let's assume that \$58 million is a relatively normal figure, a relatively small amount when you consider the entire program of six point some odd billion dollars. If the President were prepared to put \$440 additional millions into the budget for you, could you maintain benefits at their present level?

Mr. DEVINE. No, it would be \$440 million and \$136 million. If we were going to go, we might as well go the whole thing.

Representative HOYER. I am trying to establish if the \$136 million comes from the existing budget. Obviously you would have to apply some factor in order to find that it is not \$136 million new dollars and that is what I was trying to accomplish.

Mr. DEVINE. Again, with the qualifications I have made, yes.

Representative HOYER. Assuming we asked the President to come up with \$440 million, could we maintain benefits at the present level?

Mr. DEVINE. Again, with the qualification I made before that we ask the carriers to come in with basically the same kind of coverage. Some came in with somewhat more, but it would be in the ballpark.

I don't have the precise figure of what would be needed to continue the 1981 benefits.

Representative HOYER. Doctor, I want to get specific with the APWU problem. Do you have a dollar figure that would be saved by substituting two out of the four largest plans in the contributions formula?

Mr. DEVINE. This would be somewhat more than \$200 million.

Representative HOYER. \$200 plus million?

Mr. DEVINE. Yes.

Representative HOYER. A little over \$200 million.

As I understand what is happening in the Mail Handlers suit, it is your position from a legal standpoint—and I understand counsel may say you don't want to answer this question, but I presume you filed some pleadings in this case—that APWU was late, that they had not given you an offer, a final offer, a last best offer.

Mr. DEVINE. Yes.

In a preliminary hearing before Judge Pratt, he accepted our opinion but found—

Representative HOYER. Doctor, assuming that is true, it is my understanding from your testimony that the Mail Handlers would be the next carrier. They are No. 7.

Mr. DEVINE. Yes.

Representative HOYER. Assuming that they were automatically substituted, what, if any, savings would be effected? In other words, I suppose, what is the average premium benefit of the Mail Handlers' policy?

Mr. DEVINE. I would save over \$100 million.

Representative HOYER. Doctor, have any of the negotiated reductions in benefits taken effect and, if they have, what savings, if any, have been effected?

Mr. DEVINE. None have taken effect. They won't go into effect until January 1, 1982.

Representative HOYER. So there are no savings at this point in time. Now, presumably, in the budget figures that you are talking about for fiscal year 1982, how far short will the renegotiated figures bring you from January 1 through September 30, 1982? Do you understand my question?

Mr. DEVINE. No.

Senator STEVENS. The budget was projected on figures before you renegotiated with the carriers, correct? We understand there is a \$440 million shortfall because we didn't compute properly or we simply didn't ask for enough money, but in any event, there is a

\$440 million shortfall. You have now renegotiated and as of January 1 of 1982, you will be paying benefits and receiving premiums under a renegotiated figure. What will that result in with respect to the present budget figure?

Mr. DEVINE. All of that is included in the figures I have given you.

Representative HOYER. \$58 million shortfall in fiscal 1981. What will the shortfall be in fiscal 1982 you project?

Mr. DEVINE. The total shortfall?

Representative HOYER. Have you wiped out the shortfall as a result of three quarters negotiated premiums benefits and premium payments?

Mr. DEVINE. We haven't wiped out the transfer, the \$136 million. The \$200 million roughly would be saved by the two out of four proposal.

Representative HOYER. But you don't have a dollar figure as to what you could reasonably project would be your shortfall for fiscal year 1982 and, therefore, your needed supplemental?

Mr. DEVINE. Without APWU in the plan?

Representative HOYER. Have you got one in and out?

Mr. DEVINE. Yes.

Representative HOYER. What is in?

Mr. DEVINE. As part of the Big Six?

Representative HOYER. It would be \$440 million plus \$136 million. And then if you include 1981, add the \$58 million. You want to keep using that \$136 million?

Mr. DEVINE. That is part of the problem.

Representative HOYER. I don't want to belabor this but \$136 million is not part of the problem. It is in your budget now. As I understand what you are telling me, when I say in your budget, it is in the Federal Government's budget. That money is there.

Unless I am not hearing your answers, that will be a transfer from the agencies which, albeit not included as a Federal employee health benefits line item, is in the budget presumably and transferred to your shop.

Mr. DEVINE. I doubt that is the way it would be done because what would happen, as you suggested before, is that we would, on top of the 12 percent, or whatever is eventually going to go through Congress, there would have to be an additional cut in agency budgets.

It could be done that way. But, again, it is not really there. The agencies are not counting that \$136 million in their budget because they do not have the employees that we estimated that they have.

Representative HOYER. That is why they are shifting it to you.

Therefore, at the time they originally budgeted, they were given that \$136 million on the assumption they had the employees.

Mr. DEVINE. They were not given this. This is an off-budget item. They do not really have it in a physical sense. It would have to come out of their current operating expenses if it were done that way, and would result presumably in more layoffs.

Representative HOYER. Now, how much will the employer's share of the premium increase if the APWU low option plan is implemented?

Mr. DEVINE. If they increase over the——

Representative HOYER. Over present premium payments?

Mr. DEVINE. Present premium payments? In 1981? Someone will have to add them up. The employee withholding was \$892 million and the annuitants' withholding is \$462 million? We use them both, employees largely, the way the figures have been presented to you. That is what, \$1.4? \$1.354 billion? That would be 1981?

The budget projection was \$1.82 billion and our estimates would be \$2.21 billion.

Representative HOYER. Are you saying approximately \$850 million in an increase in premium payments?

Mr. DEVINE. Is that subtracting 1.3 from 2.2? Yes, \$860 million—

Representative HOYER. So after giving Federal employees a 4.8 percent cost-of-living increase in a 12-percent cost-of-living era, we are going to increase premium payments by almost a billion dollars. Is that correct?

Mr. DEVINE. But I think we should also make that comparison, and it is not going to be that much less, but probably the better thing is to compare that to the budget, which is what your assumptions have been that that is what we are talking about, and that would be \$400 million.

So in one sense the premiums under the original estimates were expected to go up, but we round them out very broadly. It would more accurately go up about \$400 million more than the original budget figures would suggest.

Representative HOYER. Doctor, do you believe you can have an open season this year?

Mr. DEVINE. That is something I have changed my mind on many times through this process. I am beginning to have less optimism that we can.

Representative HOYER. So at this point in time you have no specific plans for opening?

Mr. DEVINE. This is something where we just have to see what the courts are going to do to us; see how that action restricts our ability to have one or not have one.

Representative HOYER. Mr. Chairman, I see I have gone pretty broadly afield. If I might, I have three additional questions. How much did you project you would save by not including benefits for mental health?

Mr. DEVINE. I don't think I have those figures.

Representative HOYER. By the way, is it fair to say the projected half billion dollars by your figures, and by my rounding increase in premiums paid, does not include the figure for benefits lost? Do you understand what I am saying? We are reducing by half a billion dollars benefits paid.

Mr. DEVINE. Increasing them.

Representative HOYER. How much do you save by reducing mental health benefits? In other words, previously I paid half of a billion dollars less and I got mental health benefits. Now I pay half a billion and I don't get mental health benefits. Clearly I pay half a billion dollars more but I have lost x amount in benefits. How much does mental health cost right now?

Mr. DEVINE. First of all, I don't have the figures with me. Second, we haven't concluded negotiations as to what mental

health benefits will be. In no case, at least up until the last time I went through these figures, are we talking about eliminating mental health benefits. All those intangibles make any figure impossible to talk about.

Senator STEVENS. Mr. Hoyer, I have to chair another hearing at 11:30. I do want Mr. Biller to have a chance, if you don't mind.

Representative HOYER. Thank you.

Senator STEVENS. Mr. Devine, the problem I have about this—the time we won that vote in the Senate by three votes, I listed the parade of horrors that would take place if there was half of a billion dollars taken out of the FEHB and shifted as was proposed. The difficulty is, I understand, even without the amendment that is going to take place. I shudder to think what would happen if we lost the amendment. Are we not in a situation where the \$58 million, for Mr. Hoyer's benefit, is by virtue of the resolution carried over from fiscal year 1981 to 1982. It must be absorbed according to current law. So we are dealing with the \$440 million, but the \$440 million, as I understand it, is an error in calculations as to what the premium revenue would be or, on the alternative, the obligations under the plan. The \$440 million comes from both sides of the equation, not just from one, is that correct? It is a deficit in the total plan?

Mr. DEVINE. It is a deficit in Government payments.

Senator STEVENS. Which by necessity means either that the benefits are higher or the employee contributions are lower. Somehow they add up to \$440 million, right?

Mr. DEVINE. Yes, sir.

Senator STEVENS. My problem is that, and I went back and got Mr. Stockman's letter that he wrote to me concerning this plan and the presentation we made with the help of your people to offset that amendment. In view of the circumstance, has there been any request to OMB to meet this? I calculate that to be a 21-percent shortfall.

Mr. DEVINE. No, sir, there has not. I just don't believe that Congress is willing to increase this by half a billion dollars. I may be wrong, but that is my judgment.

Senator STEVENS. I don't think we will be willing to increase it either, but if it is properly presented as being not an increase but a real calculation of what the commitment was, it would be an entirely different matter. I am not certain what would be the outcome, but I do think it is not an increase if it was the amount we thought we were dealing with at the time. That is one of the major difficulties here, what to do with the \$440 million. I note you have got to somehow absorb the \$58 million, but at the time we were doing all this in opposition to the amendment, to take about \$500 million out of the account, we did not contemplate that there was already a \$440 million shortfall.

Mr. DEVINE. I apologize for that. This is something my staff didn't alert me to by that time. I think we set up new systems so that won't happen again. We do have a very difficult problem here.

Senator STEVENS. Ed, do you have any last questions?

Representative DERWINSKI. In the benefit reductions that you have negotiated with all the carriers, what is your estimate of savings?

Mr. DEVINE. That is a good question and I think it shows how little we have tried to use benefit reductions to offset this problem. The total benefit reduction that we put in so far is somewhat less than \$100 million out of the \$444 million.

Senator STEVENS. That is other than APWU?

Mr. DEVINE. Yes.

Senator STEVENS. And how much from APWU?

Mr. DEVINE. About \$200 million, but again it is not just a budget question. It is a question of putting the plan into some kind of order.

Senator STEVENS. Wait a minute. I want to make sure you don't have a bad record here. I am talking about how much do you look to APWU itself? I understand if you changed the APWU figure among the six it would have an impact because of the averaging, is that right? The question was, how much do you expect APWU's readjustment to contribute?

Mr. DEVINE. I am not sure. Are you asking benefits or premiums?

Senator STEVENS. Well, we are talking about total results in terms of the \$440 million deficit.

Mr. DEVINE. Under our proposed plan, the benefits would be very substantially reduced, over \$120 million, or something like that. But the premiums would go down dramatically and that is what makes them, to me, competitive. They would go from one of the highest premiums to one of the lowest premiums in the plan. It is the low premium that I believe would attract the kind of people who would make that plan healthy.

Younger people tend to go toward low premiums and low coverage policies because they tend to have less need for health benefits. They are willing to take that kind of risk when they seek coverage. One of the problems APWU has is that it has a very high percentage of annuitants who tend to be very high cost individuals to a plan. One of the ways to make the plan healthy is to attract young people to low option coverage, and that will result in a more healthy plan, with more young people with lower incidence of sickness so that they will need coverage of a plan less. I don't think it is proper to look at it strictly in terms of money saving. We came to the money savings, quite surprisingly to ourselves, in terms of a plan we put together to make the plan as a whole, the APWU plan, healthy.

Both questions of economics, in terms of the whole plan, the budget, and considerations of what kind of plan would make them attractive to the right kinds of individuals were involved in that.

Senator STEVENS. We want to hear from Mr. Biller. Let me say, as I have said before, I am not sure I speak for the people in the House, but I think we have a general agreement. The open season takes place about the time Congress is winding up its business. If there is any legislation that is contemplated with regard to this problem, including, I might add, any budget changes that must be effective by the first of the year, we have got to get at them soon. We cannot expect to get to them the first week of December. Because of the agenda of Congress, it is just impossible to take up something that would be controversial at that time that could be blocked, particularly if it would mean a change in the budget. That

is the reason I wanted to have this hearing today, for people to start thinking about it and I don't think we can resolve it here short of legislation, obviously. So that if legislation is necessary, we must have it this week. I personally don't intend to be involved in an attempted legislative solution the first of December because it is bound to fail.

If there is a requirement that legislation be involved, then I think we ought to have notice of it this week at the very latest.

I do thank you for your answers and patience. It is becoming more and more apparent to me that there is a basic error in the budget document and that it is improper to expect one union to bear the brunt, the full brunt of that. Whether all unions should be asked to participate or rather all carriers, not unions, should be asked to participate is another question. I believe you are being rather conservative. I think it would be impossible to get half a billion out of this budget at this point. Something has to be done and I think it is a matter of negotiation and will require at some time the OMB to be involved.

I do thank you for your patience and, gentlemen, I would like to hear from Mr. Biller now.

Good morning, Mr. Biller. Sorry for the timeframe. As I indicated, I do have to be at a meeting at 11:30.

TESTIMONY OF MOE BILLER, GENERAL PRESIDENT, AMERICAN POSTAL WORKERS UNION, AFL-CIO, ACCOMPANIED BY BEN EVANS, DATA PROCESSING MANAGER

Mr. BILLER. My name is Moe Biller, and I am general president of the American Postal Workers Union, an affiliate of the AFL-CIO which represents some 315,000 postal workers. The APWU health insurance plan and the APWU itself are threatened with extinction by recent proposals put forth by the Office of Personnel Management. APWU and its health plan are threatened because recent administrative actions would circumvent the law in order to reduce the legally mandated government contributions for employee health premiums.

It is my understanding that the administration is seeking budget savings, and I have no quarrel with OMB or anybody else attempting to save money. I do, however, feel it necessary to object to unfairly singling out APWU, one of more than 140 Federal health plan carriers.

I appreciate the opportunity to appear here today to set forth events of the last 2 months. I deeply appreciate the time expended on this situation by members and staff of the Subcommittee on Civil Service, Post Office, and General Services, the Senate Governmental Affairs Committee, the House Committee on Post Office and Civil Service and the Subcommittee on Compensation and Employee Benefits. I want to personally thank all who have been involved for your interest and concern. I want to make it very clear that I realize that you particularly, Mr. Chairman, and also those others who are here, recognize the very, very critical and serious impact upon the largest postal union in the world.

I will skip over a considerable amount of my prepared testimony but I do request that it be included in the record. I have listened to the testimony presented, and I think that some matters should be

responded to forthwith. Much has been made over the alleged deadline on Friday, September 25, when I was out of the country. The facts are, however, that the representatives of our union did meet with the OPM people in the afternoon on Friday, September 25, and when they were advised that the people negotiating with them could make no decisions, they requested to speak to the decisionmakers. At that time they were referred to Mr. Devine and advised they would be able to meet with Mr. Devine that day, Friday, September 25.

I realize he has a busy schedule. I am not being critical, nor do I come here with any ax to grind or any hostility. I come here for simple justice. I will describe the efforts I have made in attempting to cooperate with Mr. Devine in this regard. However, on September 25, there was no response from Mr. Devine to the general executive vice president of this union until 7:15 at night; at which time Mr. Devine was advised it would be impossible to give a total equivalency package that late in the evening, but that it would be submitted Monday morning, and it could have been submitted Friday afternoon had they not been told there was nobody there that could make any decision.

Moreover, and I state for the record, the National Association of Letter Carriers received a similar phone call around 10 p.m. on Friday, September 25, and it is a known fact that they made no written proposal either until September 28, and Mr. Sombrotto was prepared to testify in that manner under oath before the courts. We did submit an equivalency proposal on September 28, 1981. I also notice that Mr. Devine later had said we did not submit a satisfactory one on the above date. The American Postal Workers Union offers a health insurance plan to its members, and approximately 215,000 individuals and 589,000 beneficiaries are enrolled under the plan. It is a service to our members. Perhaps one of the problems is that Mr. Devine does not understand and deals with us only as an insurance organization when 90 percent of our enrollees are the members. We view this in a fringe benefit context plus the fact that our plan was begun long before the Government contributed to these plans. One of our predecessor organizations, the National Federation of Post Office Clerks, had a plan to which its members contributed. These contributions came from the employees themselves before the Government gave anything and these employees will continue to contribute to the plans.

I am sure you are aware, Mr. Chairman, and committee members, that the only reason the APWU plan impacts on the budget is the fact that we are in the Big Six. I would like to take you to when I first began the discussions with Mr. Devine. Before that I would also like to establish for the record that in addition to the premium modifications planned for 1982, APWU has recently reorganized the operation and management of its plan. When I assumed the presidency of the APWU in November 1980, I felt the plan had serious administrative deficiencies. And my communications with the membership, starting on November 14, 1980, continued to address that problem. Moreover, the contract for 1981 had already been concluded with my predecessors, and I might note criticism there.

I retained the management consulting firm of Booz, Allen & Hamilton to advise the union concerning administration of the plan. As a result of an in-depth analysis, there are already considerable cost savings and other improvements which have taken place since then.

APWU began negotiations with OPM last spring for the 1982 plan. On July 15, 1981, OPM had made a counterproposal on benefits suggesting three changes in our proposal. I verbally accepted OPM's counterproposal on July 17 and that was followed up with a letter on July 23 concluding those negotiations in terms of benefits. On July 17, 1981, we were also in negotiations with the Postal Service, and the Postal Service proposed a cap on health benefit contribution but they did not get that during the negotiations.

We understand what happened commencing August 21 and all that continued after that in the same way. The American Postal Workers Union went to court because at that time we felt we were being given no other choice.

The APWU felt the OPM did not have the sole authority to make such major changes in benefit plans. In addition, imposing changes after negotiations with OPM had been completed, and the benefit packages approved by OPM, was contrary to past practice and, APWU believes, was an attempt by OPM to break a binding agreement between OPM and APWU. It is true that this happened also between OPM and the other carriers.

Most importantly, however, APWU felt that a change of such magnitude in the benefit package violated the terms of its contract with the Postal Service and interfered with the exercise of its collective bargaining rights. Indeed, the committee should note that the timing of OPM's switch in policy—which occurred without warning, almost a month after APWU reached agreement with the Postal Service—completely deprived APWU of the opportunity to use the bargaining process to protect our membership from the harsh impact of OPM's demands.

For these reasons the APWU submitted its revised benefit package to OPM on September 28, making the benefit cuts OPM had demanded of all carriers, only under protest, and APWU brought suit to challenge OPM's authority to demand such cuts. This hearing will not resolve the issues regarding the extent of OPM's power to dictate benefit levels. That will be up to the committee to decide as it holds oversight hearings over OPM and for the courts as they hear the pending cases. I am outlining the issue here today because it is relevant to the situation in which we find ourselves.

On September 23, as I have already stated, the equivalency proposal was submitted by us and also on that date by the National Association of Letter Carriers. For some reason that was chosen to be ignored. The plan submitted by APWU was the actuarial equivalent of the reductions demanded by OPM. Confidential documents outlining the APWU plan currently pending before OPM, including tables which demonstrate that the plan is actuarially equivalent will be made available to the committee. It is this pending equivalent plan that I refer to in my testimony as APWU's plan.

On Wednesday, September 30, 1981, I did meet with Dr. Devine and expected at that time that he would approve the APWU plan since it met the requirement of actuarial equivalency. However,

Mr. Devine informed me that his budget problem was so severe that he needed to save more money. It was at this meeting that Mr. Devine first suggested a legislative change in the formula by which the Government contribution to health premiums is calculated.

You are all aware that the Government contribution is 60 percent and the manner of computation. I bring to your attention that which you have already heard this morning, that there were three other plans in the Big Six whose premiums are higher than APWU. Mr. Devine informed me that OPM could save \$150 million if APWU were out of the Big Six. The third largest employee organization plan has a lower premium plan, which would considerably reduce the premium average of the Big Six. He indicated that he needed to save \$150 million, and the only way to accomplish that would be to remove APWU from the Big Six. I was prepared to cooperate and am still prepared to cooperate. By now it is well known the efforts that have been made in order to achieve this and to obtain agreement of all of the other unions.

I will also deal with the low option package. I am trying to rush this so the Senator can hear my views and at the same time go about his necessary business. I understand the importance of all your business in all of your capacities. The facts are Mr. Devine indicated he had to save money. The only solution, according to Mr. Devine, would be to get APWU out of the Big Six, either through legislation or a nonlegislative solution, termination of APWU's health plan, which would leave the half-million beneficiaries of the APWU plan without their health plan. Those with medical conditions might be unable to secure other insurance, and some claims from 1981 would be left unpaid, with the union, and perhaps its members individually, liable for the debts. Termination of the plan at the present time, due to the unusual short-term deficit in the system, would bankrupt the largest postal employees union in the world. Moreover, even in terms of these retirees, over 40,000 members of our union, who have served their country and served their Government, are scattered all over the world. I am not sure in this type of a panic what would happen and how many would be left without insurance.

Moreover, it is important to know, if we were terminated, all of these various risks would go into other plans anyway, and they would receive the so-called burdens which I believe exist partially but have been exaggerated to create a crisis here, which is entirely unnecessary. In the last 3 weeks since I returned from a trip out of the country, a rational sitting down of all parties involved might have accomplished something more.

Mr. Chairman, I honestly do not believe that the Director of OPM understood the extent to which he would wreak havoc on retirees, widows, and the entire union membership of the largest postal workers union in the world so he could meet an OMB quota. I find out in listening here today that the figures change continuously and saving even \$120 million, which originally started out as \$150 million, would obviously not solve the problem. I have attempted to explain that to Mr. Devine, when it became clear there was agreement of all unions, AFL-CIO unions and independent unions, to seek legislation that would allow OPM to select two out

of the three unions possible. The agreement to that legislative change came about, and I told Mr. Devine on Wednesday, October 4. Incidentally, the week before that, he said he had a plan for me and would show it to me which he did on October 14. That was a \$30 low-option plan which he has spoken about today.

A description of the \$30 plan and its deficiencies is contained in my prepared statement. I can only say to you, if we lost 50 percent of our enrollees, and that is extremely likely under the \$30 plan, the plan would not be functional. We couldn't pay claims. We would have to lag a year behind. The third largest union plan, and I have no criticism of it at all, it is interesting to note, would provide some 50 percent more benefits than OPM has proposed to APWU. Therefore, the plan offered APWU could never, never make us competitive in any regard. Devine's proposal wasn't a matter we tried to ignore. We anguished over it for 2 days; we went through every possible way in which we could do it or make it fly.

Beyond that, our equivalency package brings a reduction to somewhere in the vicinity of \$468 million in benefits. The low-option package would further reduce benefits by \$180 million, or 38 percent. Moreover, there is involved the formula and computation which is a legislative matter in effect, and that was the area of my initial resistance when I returned to this country.

Gentlemen, what is being done here, postal workers are being asked to take millions of dollars out of their pockets and place it in the U.S. Treasury. We are employed by an independent Government agency and that is why I believe sincerely that the only solution is legislation. I felt Mr. Devine's original suggestion of picking the two out of three largest employee organization plans was a fair and reasonable compromise and so did two other unions.

Mr. Devine then decided to switch his demand from two of three organizations in the formula to two out of four. I told him that he had us in an administrative box and obviously it was his ultimate determination. Thankfully your concerns may be the last glimmer of hope for a union of this size. When Mr. Devine came up with the two out of four, I told him I would try to ascertain, at least among the groups, whether this could fly. As I have already pointed out and do so again here, it does not appear that such legislation would be supported.

I have discussed the proposed reduction in benefits. In our equivalency package, we were prepared to reduce \$48 to \$60 million in benefits. The low-option package would reduce it by an additional \$180 million. If you took all of the figures that I elicited here, it appears that Devine's solution is to make APWU solve this particular budget problem.

I was really pleased to hear the chairman of the committee himself advise that solving the budget problem cannot be on the back of a single organization. Then I also listened to the OPM Director pointing out when it was raised. Here we have Blue Cross-Blue Shield which is the largest of the groups and I note that they are not receiving that type of treatment. Furthermore, although OPM has authority in that area, it has not touched the comprehensive groups, because they are protected under title XIII.

So the issue is a matter of competition, with a monopoly type of thing being set up with APWU just being squeezed in between.

Perhaps it is easier to take on one of the two unions than take them all on. Certainly if a good example is made of the largest, then I don't know what will happen to the others in the coming period of time.

Moreover, to get back to the low-option plan offered APWU, its administrative costs would be prohibitive. The totally different structure of OPM's counterproposal would render 90 percent of our existing computer programs unusable. New software would be needed to reprogram the data base. All of the things that would have to be done would make it virtually impossible for APWU to accept a low-option plan. It would create enormous cash flow problems and create enormous backlog, and so on.

Yes, we have a present short-term deficit. The tables in my prepared testimony show that given a proper equivalency program, in which we will be dealt with no differently than any other insurance carrier in the health plan program, our actuary has determined that that deficit would literally be wiped out by the end of 1982. And, again, it does not mean we are even intransigent at this point: it is a fact admitted by the Director as he has been dealing and negotiating with us over these several weeks. I understand the legal protections he must take, for the same reasons we did. If we could resolve this matter, we don't have to be in court. Nor does anybody else.

APWU has a proposal pending before OPM which is actuarially equivalent to OPM's required benefit changes, and which is financially viable and will lead to elimination of APWU's deficit.

APWU has tried to cooperate with OPM, and we have gained support for removing APWU from the Big Six. This solution is acceptable to all and allows OPM to save funds and, at the same time, to approve the APWU plan which is in the interest of its members.

There is no point in terminating APWU's plan. I wonder seriously—I am certain, Mr. Chairman, if it were a private company with a \$380 million business, with 450 workers right here outside the District in Silver Spring, Md., there would be some concern on driving it out of business.

This was a plan in which employee contributions were made, as I said, and equity began even before FEHBA was around.

I would like to summarize the APWU position. It has been an approved carrier since the legislation was implemented in 1960. Our history as a health insurer to postal workers predates FEHBA by 13 to 14 years.

Our plan has been chosen by postal and Federal employees who have sought in the past a higher type of option. If you look at the Blue Cross plan, I think you understand what it is all about. They have less benefits and higher premiums. We can do the job, and we can do it with equivalency and 15 percent increase in premiums, which would wipe out our deficit by the end of the year. I am not negotiating here. I am attempting to bring a problem of the greatest magnitude to your attention.

I don't know of any larger union in the history of the labor movement of the United States of America which has been threatened with this type of extinction. I don't tell you all our members

are going to run away because there are institutional loyalties. But there will be havoc and panic.

As a matter of fact, the press has had a holiday, as you well know. They haven't gotten the leaks from me. APWU has a history of financial stability and we are a proud union. An unusual short-term deficit exists in our health plan, due to inflation and unexpectedly high utilization rates. And I would have to agree that had the premium that OPM suggested last year been taken by my predecessor, you wouldn't even have been in that position. Again, it was a negotiated thing on both sides and I don't hold either side culpable. That reached an agreement. The deficit can be made up under our equivalency plan within 1 year.

Mr. Devine's efforts to meet a budget quota have resulted in proposals of termination of the APWU plan or adoption of a low option plan which will fail, which will necessarily destroy the plan of the union.

No matter what the terminology or social differences in this administration, I cannot believe that the President of the United States or this administration wants to see the extinction of a union of 320,000 members. I cannot accept that at all, and that is why I come here seeking this solution. I agree, it has got to be done quickly. I have no quarrel with that, Mr. Chairman. The cooperation you get from us is unlimited and I am sure it is true of the other unions.

Mr. Devine's original proposal to legislate APWU only out of the Big Six and to approve APWU's equivalency plan would have no adverse impact on the budget, as you know.

Moreover, it is interesting to me that now there are bigger problems than just moving us aside out of the Big Six, which would save \$120 million. I don't tell you that is a small amount. If there is to be that savings, let's do it legislatively. If you go Mr. Devine's route, we are out of business regardless and, all you save is \$120 million.

Mr. Devine told me on Friday that since we are not taking the low-option plan—he has stated here today there is no contradiction—he is going to have to renegotiate with all the other hospital plan carriers.

I also submitted for the record a statement from the Public Employees Department of AFL-CIO. It says,

Dear Mr. Chairman: This is to advise you the Public Employees Department, AFL-CIO, met in special session Wednesday, October 7, 1981, and agreed unanimously to support legislation which would remove the Hospital plan of the American Postal Unions, AFL-CIO, from the formula by which Federal Government contributions for health benefits are determined and substitute a formula that is fair and equitable to all participants.

Sincerely, J. F. Leyden, Executive Director.

Mr. Chairman, and those of you in the Congress who have been so really concerned and interested, it brings out my innermost emotions and feelings. You don't take an individual, a human being that has a cold and douse him with pneumonia, so you will destroy him, because that cold can be cured. There is no problem here that cannot be worked out, and there is no reason to destroy the union. This has never happened before, and it is an indignity to the labor movement. This has never happened in the whole history of FEHBA.

I would like to thank you again for calling this hearing. The eventual fate of the APWU health plan will have an enormous impact not only on the future of our union, but on the lives and well-being of all APWU plan members and beneficiaries.

There is absolutely no reason why the interests and welfare of these people cannot be accommodated.

I hope it is not presumptuous on my part, nor does it place on you in the Congress a burden which you feel that you should not have to share; and, frankly, I hope it will not affect the views and terms of the courts. I recognize the law; I recognize the legislation. I think the future of this union, at least given the demands of OPM, is in your hands. I think you are our court of last resort, I really do. We can get the cooperation of the other unions. We seek a reasonable resolution to it. We are not a basket case, not one iota. We have stated that a deficit exists and we have also stated how we intend to clean it up, with the advice of Booz, Allen & Hamilton, one of the most prestigious consulting firms in this country. Had I been in office earlier, they would have been in here sooner.

The American Postal Workers Union, to resolve this problem, needs a little help. The Congress of the United States in the past has given help—I am not critical of it—to large corporations when it looked like they would be in difficulty. We don't seek a financial bailout. We are not asking the Government to give us one nickel. As a matter of fact, under any circumstances, our members will be taking money out of their pockets and putting it in the U.S. Treasury. We need a solution this week. Whatever you say, it doesn't matter what time of the day or night, we will be there and the other unions too, so they have advised me.

I cannot thank you more for this opportunity to present the situation. I hope you do understand the enormity, the magnitude of this crisis. We are 1 of the 20 largest labor unions in the AFL-CIO. We are not in desperate shape at all, but this forcing us to the wall, calling in the mortgage now, can present us with untold burdens for which the union itself doesn't have the resources.

Thank you, Mr. Chairman, and those of you who are kind enough to be here. I appreciate your time and effort in calling this hearing, and I thank each of you for your interest.

Senator STEVENS. Thank you.

When we first heard of this problem, there was an impression that this was a second round of budget cuts.

From what I understand, that is not the case and it was my understanding at the very beginning there would be no cuts applied to this budget and there have been none.

It is obvious there is a horrendous error in the computation of the cost of this fiscal year's Government contribution to the Federal Employees Health Benefit Plan. My question to you is, and I want to hear, if I can, from Mr. LaPenta, what is the status of your response to the low option proposal?

Mr. BILLER. I have told Mr. Devine it is absolutely impossible for us to accept—I have some tables here which made it very, very clear, that even if we were to retain 100 percent of our membership, it would be practically impossible to function.

If we lost 50 percent of our membership in the hospital plan, that would be disastrous, and that is a likely loss. It would be absolutely impossible for us to accept this. Moreover, it would be impossible for us to market OPM's proposed plan.

It is, as I pointed out, a reduction in benefits of an additional \$180 million.

Senator STEVENS. We then face the problem of legislation, and I can say it would be impossible to get legislation of the type that was originally suggested, taking your union out and putting another in, if it was opposed by the administration.

It is my understanding that that leads us to the question of having two carriers in and two carriers out.

I wanted to ask Mr. LaPenta, are you here, sir, Mr. LaPenta? Could you join us up here, please?

Mr. BILLER. We sat with the actuaries for 1½ days. As I pointed out, the benefits projected under OPM's proposal are actually only 50 percent of the benefits of the third organization. To me it is a matter of, do we go to the guillotine tonight or do we die of terminal cancer 6 months from now? Or to have our people come back 3, 4 months from now and say, "What did you do here? You deceived me, I now have to shop around." We would be running about a year behind in claims payments, if we lost 50 percent of our membership.

Senator STEVENS. I understand that. The difficulty is, in the manner of computing the Government's contribution by removing your union from one of the top six and removing the next one and putting in the next two, the contribution average would then come down to where this \$440 million—as I understand it, the error would be then eliminated by virtue of the averaging of the Government's contribution.

Mr. LaPenta, could you tell me what is the attitude of the other unions concerning the concept of two in and two out?

TESTIMONY OF JAMES J. LAPENTA, JR., ASSISTANT TO THE DIRECTOR, NATIONAL POST OFFICE MAIL HANDLERS, WATCHMEN, MESSENGERS, AND GROUP LEADERS DIVISION OF LABORERS' INTERNATIONAL UNION OF NORTH AMERICA, AFL-CIO, ACCOMPANIED BY MARTIN BECKER, THIRD PARTY ADMINISTRATOR, AND WILLIAM ALPER, COUNSEL

Mr. LAPENTA. Let me say something else first, if I may.

I have been around here 21 years and we have had an orderly process whereby we have been able to handle these negotiations dealing with both rates and levels of benefits.

Senator STEVENS. Have you ever had an error like this before?

Mr. LAPENTA. Yes.

Senator STEVENS. Of this magnitude?

Mr. LAPENTA. Almost as much of this magnitude.

Senator STEVENS. This is 21 percent.

Mr. LAPENTA. At one time this predecessor union, the NPU in the 1960's, had a similar type of financial problem.

Senator STEVENS. I mean in the Government's computation of what it is going to cost to contribute.

There is an error here of \$440 million.

Mr. LApENTA. You are talking about the budget process and then you are talking about the process we use to determine what the premium rates are going to be.

I would like to try and clarify that, if I may.

I do have to point out that you have only got two people to blame for the disorder in this process this year. In my opinion, you have Dr. Devine to blame and in my opinion, you have got the APWU to blame. I don't say that as criticism to the point—

Senator STEVENS. He is gone, but he didn't make up those estimates. They were made up by his predecessor, or by somebody. I am not going to blame his predecessor per se, either. The estimate that is in that budget document came from the budget process over the past 18 months.

Mr. LApENTA. He talks about a \$58 million 1981 deficit and he talks about—

Senator STEVENS. Wait a minute, first, \$58 million was a sheer error. I handled that for them in connection with that other bill. That was strictly an error in computation.

Mr. LApENTA. So what does that bring that down to?

Senator STEVENS. That is \$58 million from 1981. In 1981, someone mistakenly estimated the number of claims made. It was a computation error. We eliminated it by carrying over into 1982. We eliminated for 1981 by saying we are going to absorb that in 1982.

Devine started out this year with \$58 million that they had to absorb somehow in the process.

Mr. LApENTA. You know this.

Senator STEVENS. As we went into this, it was discovered that the estimates for the Government contribution for 1982 were \$444 million in error also. So you have to put the two together. There is a \$498 million deficit in Federal contributions to FEHBA as far as those documents are concerned that were presented in January.

There are no cuts applied to this. It is strictly two errors we have to find some way to handle.

Mr. LApENTA. Dr. Devine and his people came to all of the unions on August 21 and said we have a \$500 million deficit. You are going to have to redetermine and recompute your premiums and level of benefits.

We all did that except one union. He said there are others, one or two other unions involved.

For example, our union, in renegotiation of those rates and benefits, took our cost down below the 75 percent for next year to 67 percent. The point I want to make here, it is not just a question of equivalency. Dr. Devine made all the other unions not only negotiate equivalency, but go beyond that. In fact, he said here today he is going to get them back to the table again if they can't make a deal over here and make us further cut those premiums.

What does that mean to the Federal and postal employee?

Senator STEVENS. Let me ask you one question right there.

You are not a self-insurer, are you?

Mr. LApENTA. No.

Senator STEVENS. Did the carrier that provides your services give you notice of increased premiums for 1982?

Mr. LApENTA. Yes.

Senator STEVENS. In any event, there were increased premiums?

Mr. LAPENTA. Along with some increases in benefits.

Senator STEVENS. Apparently it is becoming clear to me that the error here is an error of estimating the scope of those increased premiums.

How much was your increase in your area, do you know?

Mr. LAPENTA. Before we went through all of these reductions?

Senator STEVENS. Yes.

How much did the carrier say it was going to increase premiums for your union?

Mr. LAPENTA. It was going to be approximately 24 percent.

When we went through the renegotiation process, the purpose was to bring down that deficit from that \$500 million and we all had to reduce our level of benefits and then, of course, make the corresponding changes in your rates.

But the point I was trying to make was that when we went into the negotiations initially, the purpose of those negotiations was to meet that deficit that he was talking about, and all the plans have negotiated downward. I just cannot believe his figures.

Senator STEVENS. You have not negotiated yet any increase in premiums as far as employees are concerned, is that correct?

Mr. LAPENTA. No; even with the reduction in benefits, there have been increases in rates.

Senator STEVENS. Those increased rates, though, came about from the—the carriers were notified. There have not been any increased premium payments required by OPM negotiation yet, have there?

Mr. LAPENTA. Yes, there have been. OPM, their actuaries—one of the points that was made, most of the carriers have come in. As Mr. Biller's plan has come in and said initially between August and September, these are the rates that our actuaries say we should be paying for this level of benefits and their actuaries said, no, these rates have got to be higher than what the actuary equivalency shows.

And that is the point I am trying to make. If you are going to treat everybody fair, then it is not just giving equivalency to the APWU because everybody else has had to give equivalency plus an increase in rates because their actuaries have said, yes, that is actuarially correct and we agree with your actuary but the rules from Dr. Devine say we have to go further. That is the point you are trying to establish here. These numbers he has been giving are all wrong.

He is making Federal and postal employees pay more out of their pockets than they are supposed to.

Senator STEVENS. My impression is the numbers going into this whole fiscal year were wrong. We know it from the \$58 million. Now we seem to know it from the \$444 million. The numbers that came from those people managing this program were wrong. As far as having two unions in and two unions out by legislation in order to reduce the average that is made up under the law, what is the position of your union on that and, to your knowledge, the other unions of the AFL-CIO as far as legislation to take two out and substitute two others in the Big Six?

Mr. LAPENTA. As long as that formula is changed and is fair and reasonable and it does not automatically take one out and put one

in, we would support changing the formula. That is the position we made clear to the AFL-CIO at the PED meeting.

Senator STEVENS. The proposal was to have APWU come out and the next one go in; that would be your union.

Mr. LAPENTA. That is correct.

Senator STEVENS. That did not accomplish the balancing of the books.

Mr. LAPENTA. No, not only accomplish it, but it would be unfair.

Senator STEVENS. It wouldn't affect APWU as much as some other things. As a practical matter, my question is, what was the position of your union on taking not only APWU out but also another carrier out so that the average would come down?

Mr. LAPENTA. Taking either one or two carriers out is not the way to go. You ought to develop a legislative formula that allows flexibility, and you ought to have criteria, and the criteria ought not be just the numbers of people, that that criteria should be a number of flexible things that you could possibly use.

The cost containment provisions of a plan, competition of the plan and not only the geographical representation but the representation of number of Federal employees, number of postal employees, number of annuitants, that is what the formulas should have in it.

Not automatically substituting employee organization A for employee organization B.

Senator STEVENS. In order to do that, it would take an agreement and I don't think you would get legislation to do that without an understanding of all participants.

Mr. LAPENTA. Then you have no other alternative.

Mr. BILLER. Mr. Chairman, I pointed out one other thing before you that I want to highlight.

In the event that legislation can't fly—that is the two out of three that was originally suggested by Dr. Devine—and we are strangled and removed, then even under the existing legislation, the next union would move up, regardless. Nothing would be accomplished but the destruction of a labor union.

Mr. LAPENTA. That is one of the things we have to talk about. I see nothing here where anybody is going to be able to destroy any employee organization or any plan.

Senator STEVENS. I agree.

There is nothing in this record that indicates there is any intention to have any adverse impact on any union. We are talking about carriers. The whole question of this hearing is the carriers under the FEHB, not a union. I don't think it is fair to impute any adverse intentions toward any union as a result of the problem here. This is strictly a problem relating to carriers and not unions.

Mr. BILLER. I have not stated it is anybody's intent, but the consequences are the same, no matter how you slice it. That is a reality.

Senator STEVENS. I don't even buy the reality, with due respect.

Mr. BILLER. I hope we don't have to face it, Mr. Chairman.

Senator STEVENS. I have got to go to this other matter.

Thank you very much, Senator.

Senator PRYOR [presiding]. First, Mr. LaPenta, do you have a prepared statement you would like to submit for the record?

Mr. LAPENTA. Senator Pryor, I was sitting in the back of the room and called up here to answer a specific question.

Yes, I do have some documents to put in the record and I have an oral statement to make.

Whatever way you want me to proceed is fine with me. I can come back at another time.

Senator PRYOR. We will be glad to receive that.

Mr. LAPENTA. I don't know if Mr. Biller and his people are finished yet.

Senator PRYOR. I am going to call on Mr. Derwinski at this time.

Representative DERWINSKI. Mr. Biller, I imagine at times like this you wished you had stayed back in New York as president of your local?

Mr. BILLER. No; I will tell you why. I came here because I knew there were difficulties. If I can't resolve them, perhaps some day somebody will.

I just want to say, Mr. Derwinski, I will never run away from a problem. My reputation is, if there is a can of worms, I want to examine it. I am happy here. I may not be happy with what is happening, but I am happy to be here.

Representative DERWINSKI. I just want to be sure I understand the chronological sequence of events.

By the way, your statement is very clear and very helpful.

Mr. BILLER. Thank you.

Representative DERWINSKI. If I could ask you to look at page 9 of your statement, you referred to the meeting of the Public Employees Department of AFL-CIO that was held on October 7. That particular meeting you stated was held on October 7?

Mr. BILLER. That is correct.

Representative DERWINSKI. Then, subsequently, on October 14, you met again with Dr. Devine?

Mr. BILLER. Yes; may I just clarify. While we were still in session, the Public Employees Department had agreed on that two out of three. While they stayed in session, I went to call Dr. Devine and explained to him we had an agreement. He says he had a package for me, and would like to meet with me on October 14 at 2 p.m. And that is what we arranged.

Representative DERWINSKI. You made it very clear you could not accept the offer that Mr. Devine has made for the low option since you estimate this would cost you at least half your enrollees?

Mr. BILLER. That is correct.

Representative DERWINSKI. So, therefore, in your meeting of the 14th with Mr. Devine, he advised you, and you correct me if I am not interpreting this correctly, that if he could not get the legislation and you could not agree to the low option, that he would, again, renegotiate the benefits as well as premiums with all the other carriers.

Mr. BILLER. He told me that on Friday, October 16, sir, not on Wednesday.

On Friday when I told him that we could not accept this plan, it was then that he said that the other unions better understand that

if they don't take the two out of four legislation and if we don't take the low option, everybody will have to reopen negotiations.

I would like to add one other thing to the record, if I may. When they say a union will not be destroyed, that is not a fact. Because if this insurance carrier goes out of business, any liabilities remaining are those of the American Postal Workers Union—we would like to have that straight.

Representative DERWINSKI. That is because you are a self-insurer.

Mr. BILLER. Ours is a self-insured plan and so is the plan of the National Association of Letter Carriers.

Representative DERWINSKI. The others have underwriters.

Mr. BILLER. Right. We all have had self-contributory plans for a number of years for which the workers contributed out of their pockets.

Representative DERWINSKI. Let me get back to the question that keeps bothering me.

In light of these developments, is it not the case that given an ultimatum for Mr. Devine to renegotiate—again renegotiate—that the Public Employees' Department might not be in agreement with you at this time?

Mr. BILLER. On the two out of three?

Representative DERWINSKI. Yes.

Mr. BILLER. Up until I arrived here, I heard of no position change. I still heard this was the solution that was being sought, and I have submitted this letter from the Public Employees Department as of today.

Representative DERWINSKI. You can understand, the last thing in the world we want to do is be caught in a union crossfire.

Mr. BILLER. I understand quite well.

Representative DERWINSKI. We hope you have solidarity like your Polish brothers.

Mr. BILLER. I would not come to you gentlemen if there was not an agreement reached on that.

Representative DERWINSKI. Only one other question.

If you were to get your solution—I realize there is no perfect solution for you—but if you were to get your solution, which would be to be removed from the Big Six and then to maintain some coverage above the low-option plan, would this automatically have an adverse effect on either the benefits or premiums of other Federal employee plans?

Mr. BILLER. That would deal, I suppose, with the method of Mr. Devine dealing with his own figures. I would like you to bear in mind, too, we don't complain. But the facts are that we have taken, or we are prepared to take, the impact which, on a plan like ours, is absolutely much greater because of the nature of the benefits and the plan.

Again, as was pointed out, and it was pointed out by the other speaker, too, increases in premiums have been sought by all of the plans.

On the original benefit package, on which OPM had reached agreement in writing, the attachment is in my statement, we would probably have had to go up in premiums around 25 or 30 percent. It would appear, at least our actuary points out, that a 30

percent increase in our premium would wipe out the deficit at the end of the year.

I don't point out any intransiency here, either. I am sure when you sit down to talk, there has to be give and take. In terms of impact on other plans, they are all impacted by this. They are asked to make both tremendous cuts in benefits and also increases in premiums. That is taking place.

Representative DERWINSKI. These figures that Senator Stevens properly pointed out were now subject, obviously, to some error, is it your personal opinion that the hand of the OPM is really being forced by OMB?

Mr. BILLER. I would have no way of knowing, but I am disturbed by one thing; that is, the desire to save some \$270 million just from the APWU—I am not arguing willingly or otherwise. The facts are, APWU is being placed in a vise, where OPM says we can resolve whatever our problem is if we cut off APWU's head. That is really what it is. It is just impossible—I could be a fool and take that low-option plan, and then as I said; 4, 5 months from now people would be after us as to what we did to them. But I am sure there are solutions here if people would sit down.

Don't forget, all they had here was a meeting and then perhaps a second meeting where people gave information. Then the individual plans negotiated separately with OPM as they had done in past years.

Representative DERWINSKI. How would you answer the questions someone else might raise that the reason you cannot accept a low-option plan is because your benefits in previous years had in some way contributed to your financial dilemma? If you had been generous with premiums, generous to the fault you became a very attractive plan and yet this contributed to the obvious deficit you face.

Mr. BILLER. It is like any mortgage. If you are given an opportunity to amortize, you have no problem. If the mortgage is called in, it doesn't matter how basically sound you are. This is not something that had ever happened before in the 20 years. We are not asking anybody else to pick up the tab for us, nor did we place ourselves in the Big Six.

As a matter of fact, it is even the other way around. It is conceivable that people would like to keep us in the Big Six with our high premiums, because our being there with the high premiums becomes a protection for all other Federal and postal employees.

That is a reality. We all know what is happening. So now, here we are. It isn't somebody else picking up our burden, really. And, again, other than in a manner of computation, we are not even in the budget-making process.

Representative DERWINSKI. But you do appreciate the fact that a legislative solution, if there is one, will obviously depend upon our understanding that all parties in dispute will support it?

Mr. BILLER. If we cannot get that, I recognize there will be no legislation. I understand that. But I think we need a meeting of minds all around.

Representative DERWINSKI. And at the same time, we understand that you are in an impossible negotiating position with Mr. Devine at the present time.

Mr. BILLER. That is the way it appears to me.

I am not going to read his motives. He obviously has many cards to play and many irons in the fire, and he is the administrator, so here we are.

The realities should be understood. We are not crying wolf. We had to reduce twice as much as the others. There should be a hesitancy and reluctance on our part of just gambling away the benefits of our members. So we came around to the equivalency position a little later, and now OPM says, "OK, pal, now the price is three times as high and must be on our backs." It becomes impossible.

Representative DERWINSKI. It appears to me even though we have been able to get some points clarified this morning, we still have a long way to go before there is unanimity behind a legislative cure and that would still leave us some problems insofar as Dr. Devine is concerned.

Mr. BILLER. Yes, every day the figure changes. On the telephone Dr. Devine said to me—it was the first time, he said—"Removing you will not save as much as \$150 million." He said that the low option plan would save him \$270 million—today I heard him say some \$200 million—and if we don't take that low option plan, then he would have to renegotiate with the other plans. I can't help that.

All I say here, we understand if there were errors in the past—and institutional errors—they didn't happen to be of my making; I discovered them when I came in, and I took as prompt action as possible. On the other hand, if there were institutional errors and we have to swallow a bitter pill now, that is fine, but let's not give me the hemlock.

Mr. LAPENTA. Mr. Derwinski, let me speak to that before I get a chance to put my documents into the record.

First of all, we know we can't depend on Dr. Devine's budget figure of \$400 million. Ergo, if you cannot depend on that, you cannot depend on his statement all the other plans are going to reduce that amount by \$100 million and the APWU is going to reduce it by an additional \$180 million on top of that with the low option. So you cannot take those figures either, believe me.

Third, you have got to recognize what they have done here and why I appear to be incensed about this whole matter, because you have got to be talking about protecting Federal and postal employees. When you introduce deductibles and coinsurance in there, let's take a hypothetical case, up to that time, the insurance has been charged \$1,000. That is what a particular medical benefit he receives costs, that is what is being billed, \$1,000. Under the \$200 deductibles, that is reduced to \$800.

The employee pays \$200 out of his pocket. You turn around and do 75-25 percent coinsurance, that is another \$200, now you are down to \$600 that the premiums are paying and the employee is paying \$400 and along comes somebody with a plan to take one of the Big Six out of the Big Six and you are pickpocketing that Federal or postal employee for the third time, because as the

Government contribution comes down, the employee contribution goes up, and that is why I am here trying to clarify this record and get away from some of the rhetoric and red, white, and blue and getting down to the facts involved in this case.

Senator PRYOR. I would like to say to Mr. LaPenta that if he is incensed, I would like to see him when he is mad.

Representative DERWINSKI. We want to come out of this with as clear a picture as is humanly possible of what all Federal employees will face once this package is resolved. In other words, we appreciate the special problems you have, but then we have to keep in mind there are 2,700,000 other Federal, civilian employees. They are all in the ball game together, whether they like it or not. That seems to be the difficult point that we cannot seem to get to.

Just what does the whole Federal civilian employee community face, and how do we best serve everybody's interest? That is our responsibility. Within it, if we solve any special problems—

Mr. BILLER. No, I have no disagreement with any of that. I certainly don't want to bring this to the point of boredom. All I am pointing out is, unless there is a legislative method of everybody dealing with Dr. Devine, or absent legislation dealing with Dr. Devine in some way, our going out of business will of necessity, regardless, bring the next organization up forward, so the immediate legislation is not something artificial. They would be in the same situation, and the Federal employees would still have to be digging in. Absolutely, the objective is to drive us out one way or the other. But, on the other hand, if I have been pushed out of the arena, I am going to fight to get back in the arena.

Mr. LAPENTA. Mr. Derwinski, there is an obvious solution to this problem. There are only two legislative things that need to be done.

One is short term and one is long term. It is obvious that the short-term legislative requirement is to get rid of that ridiculous provision in the law that says that the Government's contribution depends on the six plans that have the highest number of enrollees. That is stupid. OK? Because that is what has got us into this situation today, and I tried to point out to Dr. Devine, why are you making me pay a penalty, why are you making the other 112 plans pay a penalty when it's the Big Six who have been responsible for the \$500 million deficit, not the 112 other Government plans. So you negotiate with the Big Six. That is what Senator Stevens tried to point out. Why are you picking on the APWU? They shouldn't be picking on APWU. They should be negotiating with all the Big Six and make them restructure their plans because what has brought this about is their overutilization and their consequent underpricing and payment of first dollar, which is not done in the private sector.

Now, if they would get that out of the way, then they wouldn't have to pick on all of us little plans.

Second, it would change that formula and have the Government's contribution depend on a more flexible type of formula using some criteria like cost containment, competition between the plans, representative plans representing Federal, postal, annuitants instead of just numbers. That could take care of that. Your long-term legislative problem is to do something about the annu-

itants. I recommend you have two rates. You have a rate for the annuitants and a rate for active employees. You still allow the annuitants like the active employee to pick and choose among the 118 plans and then they will get the kind of benefits they want.

Finally, there should be no major overhaul of this law because the basic law is good. It says there should be competition so the Federal and postal employees will be offered a whole host of plans. They are beginning to think about that in the private sector. The private sector is talking about the reason costs are not contained is because employees who work for General Motors or United States Steel don't have a number of plans to choose from.

Therefore, they are captives of the plan and people paying for the plan are captive of whatever premiums want to be put on them so you have got to keep the competitive element in these plans. You don't need major legislative overhaul. You have to get Dr. Devine to sit down and negotiate fairly with these people.

Why should he offer a low option plan? I think in all fairness, he ought to just have the APWU do what we did and no more. On the other hand, I do not think the APWU should get off with doing any less. They should have a right to a high option and low option, but they should have to make those reductions in benefits and premiums like all the other plans made in order to put themselves in a financially sound proposition.

Representative DERWINSKI. I would like you to cooperate with us in working on the language you suggest for setting up a more practical criteria. I think that will be helpful. Thank you, Mr. Chairman.

Mr. BILLER. Two points that I think are important and not a matter of debate. I think things can be worked out. I realize the shortage of time. Before we blame the Big Six, and I don't owe apologies for any of them anyway, I don't think we should overlook inflation and spiraling costs, because the medical industry has been listed as one of the largest contributors to inflation. In terms of the annuitants, I think this is really the saddest thing. They have been hit with the elimination of one of their COLA's. They are faced with a possible delay from March to October of 1982, even after the elimination of one COLA. The contribution for health benefits they get from the Government is reduced once they are out on retirement—I'm talking about postal workers—from 75 to 60 percent.

These are the people that need medical coverage more than anybody else. This has nothing to do with putting our house in order, but I want to make sure we don't leave them out on the street because the elderly are important to our Nation.

Mr. LAPENTA. Mr. Derwinski, here again is what has happened in this whole affair. The people like Mr. Devine and others come in and they just don't know what they are talking about. Let me tell you how these rates are figured.

First of all, when you go in each year and negotiate like we have been doing all this period of time—21 years in some instances, 17 in others, 5 in others—the first thing taken into consideration is the inflation trend factor. All of the plans have the same inflation trend factor, so I don't get an advantage on Mr. Biller or on Mr. Somebody Else. Do you understand that? Then the next thing that

comes to pass is then they take your utilization and from that they get another rate which they add to the inflation rate.

Now that, that's where cost containment, managing your plan properly without Mr. Booz and Allen and all those people, really putting cost effective measures in, supervising the plan properly, that is where you get the advantage on then what your premium is for the next year and the third area where you get it is when you don't allow overutilization of your plan. You turn around and take your claims and make sure you pay every dollar that that person deserves but you don't pay more. OK?

That is how this thing works. When you can do that, then you can come in with a plan where it costs Federal and postal employees \$11.42 for the Mail Handlers plan. When they get the Blue Cross it would cost them \$30.52 and it would cost for the APWU something like \$25.46 for 1981. Yes, we are talking about unions, but we are also talking about a fringe benefit that is being negotiated with the Federal Government, not with the Postal Service. Now let me clear that up because I was in postal negotiations at the same time APWU was. I managed to get my proposals on the table to OPM at the same time I was in negotiations and you don't negotiate this as a fringe benefit with the Postal Service.

All you negotiate this as is a payroll withholding slot because the benefits, as was pointed out, has to be negotiated with the OPM.

Senator PRYOR. Congressman Hoyer.

Representative HOYER. I don't have any questions of Mr. Biller, and I presume Mr. LaPenta is going to offer a written statement. I would like to follow up on that.

Senator PRYOR. I have one or two short questions. I think this hearing has been very beneficial. Mr. Biller, 2 years ago GAO made recommendations about how the APWU health plan could hold down some costs. What steps are being taken to hold down costs as suggested by the GAO study of September 7, 1979?

Mr. BILLER. I must be very frank, I have not seen the GAO study. However, when I came into office November 7, I was aware that for the last several years there were claims problems. The first thing I did, so you will know, I went into that plan. I was the first general president to visit that plan. I visited there a number of times and suggested to the manager of the plan that if I was not satisfied with the steps taken, I would bring in a consulting firm, as I subsequently did, to determine not only the problem but also what to do about it. As was pointed out in the testimony and in the prepared statement and attachments, there is a statement from Booz, Allen & Hamilton as to exactly what they recommended and how those recommendations are being implemented.

Those are factors that would make it a more efficient thing. But, again, I think the major deficit as expected has been in the area of inflation and utilization and the fact that it was agreed with OPM on a 17.5-percent increase rather than a 30-percent premium increase for the coming contract year, which was before I arrived.

Senator PRYOR. I might also say, Mr. Biller, the same report also made some recommendations for OPM. I was trying to ascertain if any concrete steps had been made at the request of the GAO.

Mr. BILLER. We have taken some very serious steps and perhaps Mr. Evans can explain. Mr. Evans is our new manager. We have a

new data processing manager, a new small claims unit, and we have made a number of changes in the computer operations. If you would like to hear from Mr. Evans, I think he can elaborate on that.

Senator PRYOR. The committee would like a short statement.

Mr. EVANS. Yes, we have, Senator. We have come up with cost control and cost containment on patient diagnostic and surgery. We will not pay any claim if the outpatient diagnostic does not relate to the diagnosis or symptom. That was one item for us to look into and we have corrected that. We have established a profile for all our outpatient diagnostics so we can control it the same as we control our payments for surgery.

Senator PRYOR. I thank you very much. I would like to ask this to Mr. Biller: How does APWU plan to get itself out of its present financial dilemma or bind even notwithstanding the fact of OPM's involvement? Let's say they remove themselves from the issue at this point, how does the plan presently utilized by APWU find a way out of the dilemma?

Mr. BILLER. If OPM were prepared to sign a contract, we would have to sit down and, I suspect, again renegotiate benefits. We don't argue any more about equivalency or what equivalency would require in times of premiums. What has brought this about seems to me our being part of the Big Six; as you well know, the Big Six premiums impact upon the other plans.

Senator PRYOR. What would be the major differences between what you might offer as a plan and what OPM thinks your plan should look like?

Mr. BILLER. We have offered an equivalency plan with a reduction between \$48 and \$68 million in benefits. The low option plan that OPM has given us is a \$180 million reduction in benefits. Again, although OPM said we seek special privileges, I am certain that our reduction of benefits is probably greater than anybody's because of the situation we were in in the nondeductible area before. But if we have to go to a deductible and coinsurance, we are not seeking any special privilege there.

Senator PRYOR. Mr. LaPenta, it is my understanding you do have a statement and I am wondering if you would like to give that statement at this time. We will be glad to receive it. If you don't have it typed up ready for circulation, we would be glad to try to hold the hearing record open for a few days or you can hit the highlights, if you want.

Mr. LAPENTA. Let me tell you the circumstances. I would like to bring a couple of my people up, if I may. I don't want to impinge on Mr. Biller and his people wanting to get in the record what they want.

Senator PRYOR. Are there further comments, Mr. Biller, you would like to make in conclusion?

Mr. BILLER. The only point I make, and I think it has been a little distorted, was that the Postal Service had come into negotiations with a proposal that put a lid on the premiums that they contribute. That proposal was rejected. This has been confused quite a bit. Moreover, in terms of a suitable plan, if we were permitted to negotiate further, that is, to reach an agreement—because we have in fact been negotiating and don't seem to go anywhere—we have

to find a way of balancing off both a reduction in benefits and the nature of premium increases. However, we have to deal with that in order to bring about a balancing of our books by the end of next year.

Our program of September 28 shows exactly what we can do and how we can clear that deficit up by September 1982. Our plan is very viable. On the other hand, if OPM has some different ideas, fine, but when OPM gives us a terminal cancer case, I can't sell that as a medical benefit.

Senator PRYOR. Thank you, Mr. Biller. For the record, I do wish you would list the names of the associates you do have at the witness table.

Mr. BILLER. General Counsel, Darryl Anderson, to my right and Ben Evans, director of the hospital plan, to my left. There are the two administrators of the plan in the room too, Mr. Kowalczyk and Mr. Kaczor. I thank all of you, and I hope we can arrive at some solution to this very quickly.

Senator PRYOR. Thank you.

Mr. LaPenta, should you desire, you may bring up your associates.

Mr. LAPENTA. I have with me counsel for the plan, Mr. William Alper, and administrator of the plan, Mr. Martin Becker.

I have some documents I want to submit for the record. First, let me say I was called Friday that there was a hearing and because of the circumstances, which I think everybody now understands, in the business of automatically say moving our plan into one of the Big Six, I take it from that I was asked to appear.

Let me make one thing perfectly clear, I do not want to see, I will not support any attempt to terminate the APWU's health benefit plan. I think the APWU should be treated just like every one of the other plans. They should have a right to their health benefit plan.

For the record, I have some documents here that I would like to submit. One is a letter that I sent to William Welsh, staff director, Committee on Post Office and Civil Service. Another to Jamie Cowen, chief counsel, Subcommittee on Civil Service, Post Office, and General Services. Attached to my communication is a number of documents dealing with the health benefit plan. There are some three documents attached to that. I would like them to be submitted into the record.

Second, I would like to submit into the record Mr. Devine's letter to our plan, indeed all of the plans, of September 18 which we received September 21 where he talks about his analysis of this crisis situation.

Third, I would like to submit for the record a statement from Gary R. Nelson, Associate Director for Compensation, who has done his deed and has now left the OPM, his statement of August 21 in which he called this situation an emergency. Finally, I would like to submit a letter I sent to Mr. George MacWhorter, who is one of the persons, staff people in the OPM, when we started these crisis redeterminations, renegotiations. I pointed out at that particular time that my agreeing to equivalency or less equivalency was subject to redetermination that all plans were going to be treated the same. I think it has to be put in the record because it is being

made to appear here that somebody is taking advantage of the situation.

Senator PRYOR. Without objection, the documents you have mentioned will be received by the subcommittee and placed in the record at the conclusion of your testimony.¹

Mr. LAPENTA. If I may, as I said earlier, I have 21 years experience in this town as a union official. I happen to also be executive director of the Mail Handlers benefit plan. I wish you would bear with me a few minutes. I want to give you my version—

Senator PRYOR. Before you do that, let me express my apologies. I have to be on the Senate floor at 12:20. Congressman Derwinski and Congressman Hoyer are going to take over and we do appreciate very much your attendance.

Mr. LAPENTA. Thank you very, very much. I appreciate you listening to my earlier remarks.

Senator PRYOR. I enjoyed them. It added a little life to an otherwise boring day.

Mr. LAPENTA. As I had said before, we have always had an orderly process for the negotiation of level of benefits and premiums for the health benefit plan. Even when we have had some particular tough situations, and I alluded to one in the 1960's where the NPU, which was an independent postal union which later merged with the APWU, grew substantially both in numbers and enrollees in the health benefit plan and there were some problems with the reserves, the financial structure, the management, similar to some of the problems apparently going on with the current APWU plan. And very briefly, here is how that procedure works. In the spring of each year, OPM sends out a call letter to all of the carriers and sets some guidelines as to what they are expecting the people to come in with insofar as those negotiations.

They generally set some guidelines.

Going back, say, 20 years, in the 1960's, most of the emphasis was on increasing the benefits and this is where their problems began because increasing the benefits and slowly, inexorably moving toward paying first dollar, you had an open-ended kind of situation that you could not control when inflation took place. As a result of that, a number of the plans, particularly the Big Six, went forward, with one exception, with paying first dollar. As a consequence of that, while their benefit levels went up, their premium rates went up and along came the 1970's when Federal and postal employees were facing hard times in their pocketbook. Like other people, they began to become attracted to plans that had lower premiums, plans structured to try and give an across-the-board level of benefits but at the same time contain costs so their premiums could be attractive.

And each year in the spring, you would go through and start your negotiation procedure. First you would negotiate benefits and inflation trends and then you would follow up in negotiations of experience and utilization rates and by August or September, you would come in with a price and a benefit and that would be published and everybody would get ready for the open season so the postal and Federal employees could pick and choose from

¹ See p. 83.

amongst the plans which one they would have for the next calendar year.

Generally they became effective the next pay period in January.

I want to point out something I don't think has been pointed out and that is the uniqueness of the contracts. These health benefit programs are the means by which Federal employees can receive indemnification or prepaid health benefits and, therefore, there are two parts to this contract that we enter into with the OPM. The other contract is the carriers' contract with the Government that authorizes and enables the carrier to offer the sale of this health benefit package. The OPM—I think this is important, I emphasize it—the OPM is not purchasing services to be rendered by the Federal Government. It is providing a means by which Federal employees can receive either prepaid health benefits or be indemnified for the expenses incurred in obtaining health services.

A contract comes into existence between the Federal employee and the carrier when the Federal employee selects the plan. The Federal employees are the purchasers, not the Government, not Dr. Devine. I think that is important.

Now let me tell you what happened this year. As I said, I will keep it brief. The usual call letter went out in the spring. Everyone who has had any experience whatsoever, and I take it that the only people who haven't had experience have been Dr. Devine and Mr. Biller with how this procedure works. Everybody else has been talking for years that something has to be done. Now, Mr. Gary Nelson, who is the Associate Director for Compensation for the OPM, and Kevin Burns, Assistant Director for Compensation, knew that the Government's increase last year was not 10 percent. The Government's increase in its contribution as an employer was not 10 percent, it was 16 percent and that was going to go up next year approximately 26 percent.

So why they waited until the spring, until April, until August 21, to call us into this emergency meeting and why they never told Dr. Devine that, I do not know. But in the meantime, talk about how the silly season comes about in this town, in the meantime, Mr. Burns took all of the people over at OPM who were working for the employee organization plans and all the employee organizations had years of familiarity with these people, he moved them over to the comprehensive plans. And he moved the comprehensive employees over to the Government-wide plans and the Government-wide employees over to the organization plans.

Now, do I need to tell you what kind of a three-ring circus that developed into in April, May, June, and July? Then comes August 21. On August 20, we get a call, no agenda, we can't tell you what it is all about but there is an emergency. Come to the OPM auditorium and we all dutifully did that and that is when we received that letter I told you about. Chicken Little says the sky is falling down and we now have a \$500 million deficit and you all are going to have to have a \$200 deductible per person, 75-25 percent coinsurance and going to have to take any of your outside, hospital payment and put them in your supplemental plans because you are going to have to pay for this \$500 million.

That was August 21, this great emergency meeting. All of a sudden they go off the blip screen, we don't hear from them again.

Along comes September 22 and then we get—August 21 was an emergency, OK? September the 22, Dr. Devine's letter I submitted for the record, now we have a crisis, now we have 3 days to resolve the crisis because in his letter he says that on September 25, we have got to get everything in, OK?

Now, we went from an emergency to a crisis to September 25, the people who couldn't keep their cool, the pros, the guys in class D, came up and are now playing major league ball, choked up and all of a sudden on September 25 came this big panic. Then we got into the position of philosophers and the guys who like to be argumentative and people who think they are great debaters, and we got into this business of who is right and who is wrong—"You are burning down my house." "No, you are burning down my house"—and we are now at the point where we are today, where the solution to the problem is to make people negotiate and treat everybody fairly.

Then move on and take legislative remedial action that is necessary here in the short term and then take the long-term remedial legislative action because we do have to do something with annuitants and we have got to treat them fair. Again, I don't want to make it appear as it has been made to appear that there is only one organization who is worrying about the annuitants. We are all worrying about the annuitants and we want them to have a level of benefits across the board like everybody else but the rates have got to pay for that.

Gentlemen, you can't get away from that. Those are insurance plans. They have to be actuarially sound and your premium rates have to pay for the benefits you select. If it doesn't happen that way, then the benefits have to be reduced so the premiums will pay for the benefits. You can no longer have underpricing and overutilization. Everybody has to get their house in shape—everybody. That is what has been happening these past 6 or 7 weeks. None of us have liked it. I was plenty mad when I came in with my actuaries and got myself down to 75-25 percent coinsurance and they put the screws to me and now I am down to 67 percent. That is the story. That is my version of the story. I was there and that is how I see it happening. And I close on that note and I close again by saying I don't think anybody ought to be terminated.

In fact, going over some of this with my counsel, some of the critical points that I do want to make, I think it just would be totally out of context of the law if the APWU is terminated in the manner in which it was being maybe proposed. I think a dangerous precedent would be set if that is allowed because you are letting an appointed official take this action.

Now, again, there are established procedures published in detail requiring due process. Why APWU didn't use those procedures, I don't know. You will have to ask them. They went to court, that is their business. I am not going to quarrel with them. I am going to support them in that I don't want to see them terminated. I am not going to support them if they get an advantage over me or some of the other organizations trying to make some sense out of this thing. Again, I want to point out, I think all of us are in the same boat, the situation that has created this problem wouldn't have been created if they had been doing their jobs.

The long statement I submitted for the record speaks very eloquently and is very precise to what they are doing over there in terms of three regulations. Thank you, gentlemen.

Representative DERWINSKI [presiding]. Thank you, Mr. LaPenta. It seems to me you would make a much better witness if you weren't such a quiet individual. I keep trying to get to the guts of the problem. The guts of the problem seems to be we have Dr. Devine with his budget pressure. We have the individual plans which will be able to adjust, some more painfully than others, and the need to share the budget impact and then last but not least, we have the Federal employee and the annuitant whose primary concern is to have fair and proper benefits. I am more and more convinced, as you indicated, that we have to be as much concerned with the long-term cure as the short-term cure.

I would appreciate if you would apply your general philosophy to the degree you can, give to us some suggestions to both short-term and long-term cures. Our staff will be available to work with you. That is the only effort we can logically direct ourselves to. With that, Mr. Hoyer, I turn the questioning over to you.

Representative HOYER. Mr. LaPenta, you did mention of course the short-term and long-term solutions, actions that ought to be taken. If we conclude that there is a political problem between the various organizations representing various carriers, what do you believe is a consensus position that could be reached within the next 48 or 72 hours to offer remedying legislation? Senator Stevens and Mr. Derwinski, both of whom have far more experience than I, and I tend to agree with both of them, wish to know if there is a consensus position you think can be reached quickly enough so the legislation could be adopted?

Mr. LAPENTA. I don't see how you can reach a consensus unless you come up with a formula or criteria to determine what the Big Six—whatever it is going to be because it has an impact on all Federal and postal employees. It doesn't just have an impact on the 250,000 in the APWU plan. It has to be done and I think it could be done—if it can't be done before you go out on recess, it has to be one of the first orders of business next year, in my opinion. What really has to be done right here is to get Dr. Devine to sit down and negotiate with the APWU as he did with the other people.

Mr. Biller knows about negotiations. You can get a negotiated agreement in a couple of hours here if they went to work today, did their business. They could have an agreement in a couple of hours here and have the same treatment that the other people have had and we can publish those rates.

Let me tell you how further you are hurting the Federal and postal employee. There is some way, and I say this, I soberly measure my words, if somehow this open season is sabotaged by the jockeying of these two parties, one to get an advantage over the others, then you are locking these Federal employees not only into high rate plans but into benefits they might want to get out and I will play bleeding heart now. Suppose a person has acquired some sort of heart condition or high blood pressure and needs prescription drugs and is in a plan that doesn't have that and wants to get into a plan with it—don't just listen to one side of the story here. You have to have that open season which gives these people a

choice, three and a half million active, and annuitants, Federal and postal employees, you have to give them a choice based on their medical position.

You have got to get Dr. Devine and Mr. Biller to sit down and come to an agreement like the other plans did. Then take this corrective action about who is going to be factored in a formula to determine the employer, the Government's contribution and then move on to solving the annuitants' problems.

Representative HOYER. Do you believe Dr. Devine wants that to happen?

Mr. LAPENTA. I don't know. I am sure, now that this is public and you Congressmen have some information you haven't had before, I am sure he is not going to be so insulated and isolated down there, apparently not listening to the right drummer. I think the Congress knows how to make people march when it is time to make them march.

Representative HOYER. I have not been here long enough to know if that is the case.

Mr. LAPENTA. You were in the State legislature, Congressman Hoyer. You are not here because you didn't know your way around.

Representative HOYER. I had a different situation. I was generally always dealing with somebody within my own party.

Mr. LAPENTA. I think your credentials are great.

Representative HOYER. Thank you. The problem apparently is we have what is called an impasse, I suppose. Moe Biller feels Devine wants to put him out of business. Devine feels if he doesn't put pressure on Biller, he is not going to be able to solve his economic problems. Whatever drum we beat here, I don't know how loud it is going to be heard in Devine's shop. Senator Stevens and Mr. Derwinski are saying that if there is no consensus position upon which to draft legislation and put the heat on somebody, then we are going to impose—

Mr. LAPENTA. Not only have the Federal employees had their pockets picked by the coinsurance and deductibles, you are going to take legislative action which is automatically going to put one plan into another plan's place and by doing that, you are going to make Federal employees pay more of their contribution because the Government's contribution will come down.

Representative HOYER. Thank you, sir.

Representative DERWINSKI. I would think we made headway this morning in the sense that we got everything out in the open. There are an awful lot of rumors floating around Federal employee circles. Rumors tend to be exaggerated. What we have here are a couple of targets. I would suggest we shift the next hearing over to the House side and pick up where we left off here. I would think if there is any logical way we could have Mr. Biller and company, and Dr. Devine and his group, make one more stab at compromise, and if that in the process would not be adverse to all the other plans renegotiated prior to this, at least that is worth an effort.

I appreciate everybody's participation and I especially appreciate Mr. LaPenta helping to clarify the issues. I would hope when we get over to the House side you will start educating our members.

In the meantime, I have been in touch with Mr. Donahue at the AFL-CIO. He advises me that he had no objection if we called a meeting of all the affected unions to see if we could work out a compromise. I had a feeling he knew better than to try himself. I am not so sure we are anxious to charge into that. Obviously that has to be one of the factors before we get anywhere.

[Mr. Biller's prepared statement, with attachments, and documents submitted by Mr. LaPenta follow:]



American Postal Workers Union, AFL-CIO

217 14TH STREET, N. W., WASHINGTON, D. C. 20005

STATEMENT
OF
MOE BILLER, PRESIDENT
AMERICAN POSTAL WORKERS UNION, AFL-CIO
BEFORE THE
SUBCOMMITTEE ON CIVIL SERVICE AND GENERAL SERVICES
OF THE
U. S. SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS
OCTOBER 19, 1981

MR. CHAIRMAN, MY NAME IS MOE BILLER, AND I AM GENERAL PRESIDENT OF THE AMERICAN POSTAL WORKERS UNION, AN AFFILIATE OF THE AFL-CIO, WHICH REPRESENTS 315,000 POSTAL WORKERS. THE APWU HEALTH INSURANCE PLAN AND THE APWU ITSELF ARE THREATENED WITH EXTINCTION BY RECENT PROPOSALS PUT FORTH BY THE OFFICE OF PERSONNEL MANAGEMENT. APWU AND ITS HEALTH PLAN ARE THREATENED BECAUSE RECENT ADMINISTRATIVE ACTIONS WOULD CIRCUMVENT THE LAW IN ORDER TO REDUCE THE LEGALLY MANDATED GOVERNMENT CONTRIBUTION TO EMPLOYEE HEALTH PREMIUMS.

IT IS MY UNDERSTANDING THAT THE ADMINISTRATION IS SEEKING BUDGET SAVINGS. I HAVE NO QUARREL WITH OPM ATTEMPTING TO SAVE MONEY, I DO OBJECT, HOWEVER, TO ACTIONS WHICH UNFAIRLY SINGLE OUT AND IRREPARABLY HARM THE APWU, ONE OF MORE THAN 140 FEDERAL HEALTH PLAN CARRIERS.

I APPRECIATE THE OPPORTUNITY TO APPEAR HERE TODAY TO SET FORTH THE EVENTS OF THE LAST TWO MONTHS. I DEEPLY APPRECIATE THE TIME EXPENDED ON THIS SITUATION BY MEMBERS AND STAFF OF THE SUBCOMMITTEE OF CIVIL SERVICE AND GENERAL SERVICES, THE SENATE GOVERNMENTAL AFFAIRS COMMITTEE, THE HOUSE COMMITTEE ON POST OFFICE AND CIVIL SERVICE, AND THE SUBCOMMITTEE ON FEDERAL EMPLOYEE BENEFITS. I WANT TO PERSONALLY THANK ALL WHO HAVE BEEN INVOLVED FOR YOUR INTEREST AND CONCERN.

THE AMERICAN POSTAL WORKERS UNION OFFERS A HEALTH INSURANCE PLAN TO ITS MEMBERS AND OTHER FEDERAL EMPLOYEES UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS ACT (FEHBA). APPROXIMATELY 215,000 INDIVIDUALS ARE ENROLLED IN THE PROGRAM: 193,000 ARE MEMBERS OF THE APWU, OF WHOM 42,000 ARE RETIRED, AND 22,000 ARE OTHER FEDERAL WORKERS. MOST ENROLLEES CHOOSE FAMILY COVERAGE, SO THE TOTAL NUMBER OF BENEFICIARIES UNDER THE PLAN

is 589,000. The APWU offers its plan as a service to its members. Ninety percent of plan enrollees are members of the Union and Postal Service retirees. The APWU plan is a non-profit plan, underwritten solely by the Union. The Union has chosen to underwrite the plan to keep the element of profit out of the premiums its members have to pay.

The APWU was created in July 1971 with the consolidation of five smaller postal workers unions, including the United Federation of Post Office Clerks and the National Postal Union (NPU). Several of the unions in the consolidation had health plans which were supported totally by employee contributions. My home local postal workers union, the New York Metro, which I served as President for 21 years, started its own health plan in 1946 or 1947. Six officers of the local personally borrowed \$5,000 each in 1959 to augment the equity in the plan which was used to underwrite the NPU health plan in 1960.

The health plan of the United Federation of Post Office Clerks, which was started around 1948, was consolidated with the NPU plan on January 1, 1972 to form the APWU plan. Thus the APWU plan, through its predecessor plans, predates the passage of the Federal Employees Health Benefits Act, which now regulates its conduct.

From 1972 to 1974, APWU offered two plans, one high option and one low option plan. The low option plan was dropped in 1974 due to insufficient enrollment. The preference of APWU members was clearly for a high option plan. From 1971 until 1979, the APWU plan maintained a positive reserve consistent with APWU and its predecessor plans long history of financial stability.

Since most members of the APWU plan are postal workers,

THE POSTAL SERVICE, NOT THE FEDERAL GOVERNMENT PAYS THE EMPLOYER PORTION OF THE PREMIUM. TABLE I ON PAGE 3 OF MY TESTIMONY GIVES THE HISTORY OF THE RESERVE FROM THE TIME THE PLAN WAS CONSOLIDATED THROUGH THE PROJECTED YEAR-END STATUS FOR 1981.

TABLE I
APWU HEALTH PLAN
RESERVE STATUS 1971-1981

YEAR END	ACTUAL RESERVE (\$ MILLIONS)	ONE MONTH RESERVE* (\$ MILLIONS)	PREMIUM INCREASE
1971	5.1	2.4	---
1972	4.7	6.2	8.4%
1973	7.2	6.6	21.3%
1974	1.1	7.1	---
1975	8.2	8.9	36.8%
1976	11.5	12.2	---
1977	12.7	13.8	13.3%
1978	18.0	15.7	8.5%
1979**	3.5	17.3	7.1%
1980	-26.0	19.5	8.4%
1981	-45.0	23.1	17.5%

* THE ONE MONTH RESERVE COLUMN SHOWS THE AMOUNT NEEDED FOR A ONE MONTH RESERVE.

** DATA ESTIMATED DUE TO A COMPUTER SYSTEM CHANGE.

DURING THE PAST THREE YEARS THE APWU HEALTH PLAN HAS EXPERIENCED UNEXPECTED INCREASES IN UTILIZATION RATES. THE RECENT INCREASE IN UTILIZATION OF HEALTH INSURANCE BENEFITS AND UNUSUALLY HIGH INFLATION HAVE AFFECTED ALL HEALTH-PLANS, PARTICULARLY

HIGH-OPTION PLANS. APWU'S EXPERIENCE HAS RESULTED IN A SHORT TERM DEFICIT IN THE SYSTEM WHICH WILL NECESSITATE A PREMIUM INCREASE FOR 1982. ACCORDING TO THE ACTUARIAL FIRM OF GABRIEL, ROEDER, SMITH & COMPANY IF APWU'S 1981 PLAN WERE CONTINUED, THE BENEFIT INCREASE NEEDED WOULD APPROACH 30 PERCENT. IF RECENTLY PROPOSED BENEFIT REDUCTIONS ARE APPROVED, A SMALLER PREMIUM INCREASE OF AROUND 15 PERCENT WOULD BE NEEDED TO ELIMINATE THE DEFICIT.

IN ADDITION TO THE BENEFIT AND PREMIUM MODIFICATIONS PLANNED FOR 1982, APWU HAS RECENTLY REORGANIZED THE OPERATIONS AND MANAGEMENT OF THE PLAN. WHEN I ASSUMED THE PRESIDENCY OF THE APWU IN NOVEMBER 1980, I FELT THE PLAN HAD SERIOUS ADMINISTRATIVE DEFICIENCIES. I RETAINED THE MANAGEMENT CONSULTING FIRM OF BOOZ, ALLEN AND HAMILTON TO ADVISE THE UNION CONCERNING ADMINISTRATION OF THE PLAN. AS A RESULT OF AN IN-DEPTH ANALYSIS AND THE IMPLEMENTATION OF RECOMMENDATIONS MADE BY BOOZ, ALLEN AND HAMILTON, OPERATIONAL IMPROVEMENTS AND ADMINISTRATIVE COST SAVINGS ARE VISABLE ALREADY FROM OPERATIONAL CHANGES MADE IN AUGUST 1981. THESE SAVINGS AND EFFICIENCIES WILL FURTHER STRENGTHEN THE APWU PLAN. ATTACHMENT A TO MY TESTIMONY CONTAINS STATEMENTS FROM THE MANAGEMENT CONSULTING FIRM AND THE ACTUARIAL FIRM CONCERNING THE VIABILITY OF APWU'S PLAN.

BECAUSE OF THE DEFICIT IN THE PLAN, APWU ORIGINALLY PLANNED TO INCREASE PREMIUMS SIGNIFICANTLY IN 1982. IN THE SPRING OF 1981, APWU AND OTHER INSURANCE CARRIERS BEGAN THE YEARLY NEGOTIATION WITH THE OFFICE OF PERSONNEL MANAGEMENT ON HEALTH BENEFIT PACKAGES FOR THE FOLLOWING YEAR. ATTACHED TO MY TESTIMONY IS A LETTER I RECEIVED FROM OPM ON APRIL 2, 1981, CONCERNING NEGOTIATIONS FOR 1982. ON APRIL 27, 1981, APWU SUBMITTED A PROPOSAL FOLLOWING THE INSTRUCTIONS IN THE APRIL 2 LETTER. NEGOTIATIONS BETWEEN APWU AND OPM WERE CARRIED ON IN MAY, JUNE AND EARLY JULY. BOTH APWU AND OPM WERE AWARE

OF THE DEFICIT IN THE SYSTEM AND THE NEED FOR A LARGE PREMIUM INCREASE.

ON JULY 15, 1981, OPM MADE A COUNTER PROPOSAL ON BENEFITS SUGGESTING THREE CHANGES IN OUR PROPOSAL. ON JULY 17, 1981, I VERBALLY ACCEPTED THE COUNTER PROPOSAL SETTING THE BENEFIT PACKAGE FOR APWU'S PLAN FOR 1982 WITH A LETTER OF ACCEPTANCE FOLLOWING ON JULY 23, 1981. LETTERS OF NEGOTIATION ARE CONTAINED IN ATTACHMENT B OF MY TESTIMONY.

AS YOU KNOW, APWU AND OTHER POSTAL UNIONS WERE INVOLVED AT THAT TIME IN COLLECTIVE BARGAINING WITH THE POSTAL SERVICE. ON THE EVENING OF JULY 17, THE SAME DAY I ACCEPTED OPM'S BENEFIT PROPOSAL, THE POSTAL SERVICE MADE ITS WAGE AND FRINGE BENEFITS PROPOSALS IN COLLECTIVE BARGAINING. THE POSTAL SERVICE PROPOSED TO FREEZE THE DOLLAR LEVEL OF ITS CONTRIBUTIONS FOR HEALTH INSURANCE AT THEIR PRESENT LEVEL. THEY DID THIS BECAUSE THEIR CONTRIBUTIONS, LIKE FEDERAL AGENCY CONTRIBUTIONS, ARE CALCULATED AS A PERCENTAGE OF THE "BIG SIX" FEHBA PREMIUMS. AND THEY WELL KNEW - AS WE ALL DID - THAT PREMIUMS WOULD INEVITABLY RISE DUE TO INFLATION AND UTILIZATION.

IN THE NEGOTIATIONS WHICH CONTINUED FOR THE NEXT FOUR DAYS, APWU BARGAINED FOR A TOTAL COMPENSATION PACKAGE WHICH WOULD BE ACCEPTABLE TO ITS MEMBERS. THE TOTAL PACKAGE INCLUDED THE LEVEL OF HEALTH BENEFITS FOR 1982 WHICH HAD BEEN PROPOSED ON JULY 17 BY OPM. NEGOTIATIONS WERE COMPLETED BETWEEN THE UNIONS AND THE POSTAL SERVICE ON JULY 21, 1981, AND OUR MEMBERSHIP RATIFIED THE AGREEMENT ON THE BASIS OF THE TOTAL LEVEL OF COMPENSATION, INCLUDING HEALTH INSURANCE BENEFITS.

ON AUGUST 20, 1981, APWU'S HEALTH PLAN ADMINISTRATOR WAS INVITED BY TELEPHONE TO ATTEND AN OPM MEETING ON AUGUST 21, 1981. AT THAT MEETING, ALL INSURANCE CARRIERS WERE ASKED TO REDUCE BENEFITS BY IMPOSING A \$200 DEDUCTIBLE AND

CO-INSURANCE WITH A 75-25 PERCENT RATIO. APWU WAS TOLD IN AN OPM MEMORANDUM DATED SEPTEMBER 9, 1981 THAT APWU ALSO COULD SUBMIT EQUIVALENT PROPOSALS AS LONG AS THE TOTAL REDUCTIONS EQUALED THE COST REDUCTION THAT WOULD BE ACHIEVED BY THE DEDUCTIBLES AND CO-INSURANCE PROPOSED BY OPM.

THE APWU FELT THAT OPM DID NOT HAVE THE AUTHORITY TO MAKE SUCH MAJOR CHANGES IN BENEFIT PLANS. IN ADDITION, IMPOSING CHANGES AFTER NEGOTIATIONS WITH OPM HAD BEEN COMPLETED AND BENEFIT PACKAGES APPROVED BY OPM WAS CONTRARY TO PAST PRACTICE AND, APWU BELIEVES, WAS AN ATTEMPT BY OPM TO BREAK A BINDING AGREEMENT BETWEEN OPM AND APWU ON OUR HEALTH BENEFIT PACKAGE. MOST IMPORTANTLY, APWU FELT THAT A CHANGE OF SUCH MAGNITUDE IN THE BENEFIT PACKAGE VIOLATED THE TERMS OF ITS CONTRACT WITH THE POSTAL SERVICE AND INTERFERED WITH THE EXERCISE OF ITS COLLECTIVE BARGAINING RIGHTS. INDEED, THE COMMITTEE SHOULD NOTE THAT THE TIMING OF OPM'S SWITCH IN POLICY - WHICH OCCURRED WITHOUT WARNING, ALMOST A MONTH AFTER APWU REACHED AGREEMENT WITH THE POSTAL SERVICE - COMPLETELY DEPRIVED APWU OF THE OPPORTUNITY TO USE THE BARGAINING PROCESS TO PROTECT OUR MEMBERSHIP FROM THE HARSH IMPACT OF OPM'S DEMANDS.

FOR THESE REASONS THE APWU SUBMITTED ITS REVISED BENEFIT PACKAGE TO OPM, MAKING THE BENEFIT CUTS OPM HAD DEMANDED OF ALL CARRIERS, ONLY UNDER PROTEST, AND WE BROUGHT SUIT TO CHALLENGE OPM'S AUTHORITY TO DEMAND SUCH CUTS. THIS HEARING WILL NOT RESOLVE THE ISSUES REGARDING THE EXTENT OF OPM'S POWER TO DICTATE BENEFIT LEVELS. THAT WILL BE UP TO THE COMMITTEE TO DECIDE AS IT HOLDS OVERSIGHT HEARINGS OVER OPM, AND FOR THE COURTS AS THEY HEAR THE PENDING CASES. I HAVE OUTLINED THIS ISSUE BECAUSE IT IS RELEVANT TO THE SITUATION WE FIND OURSELVES IN TODAY.

ON SEPTEMBER 28, 1981, APWU AND THE NATIONAL ASSOCIATION OF LETTER CARRIERS, WHO HAD ALSO QUESTIONED THE RIGHT OF OPM TO REDUCE BENEFITS, BOTH SUBMITTED REDUCED BENEFIT PROPOSALS TO OPM. THE PLAN SUBMITTED BY APWU IS THE ACTUARIAL EQUIVALENT OF THE REDUCTIONS DEMANDED BY OPM. CONFIDENTIAL DOCUMENTS OUTLINING THE APWU PLAN CURRENTLY PENDING BEFORE OPM, INCLUDING TABLES WHICH DEMONSTRATE THAT THE PLAN IS ACTUARIALLY EQUIVALENT WILL BE MADE AVAILABLE TO THE COMMITTEE. IT IS THIS PENDING EQUIVALENT PLAN THAT I REFER TO IN MY TESTIMONY AS APWU'S PLAN.

ON WEDNESDAY, SEPTEMBER 30, 1981, I MET WITH MR. DEVINE, DIRECTOR OF OPM. I EXPECTED AT THAT TIME THAT HE WOULD APPROVE THE APWU PLAN SINCE IT MET THE REQUIREMENT OF ACTUARIAL EQUIVALENCY. HOWEVER, MR. DEVINE INFORMED ME THAT HIS BUDGET PROBLEM WAS SO SEVERE THAT HE NEEDED TO SAVE MORE MONEY. IT WAS AT THIS MEETING THAT MR. DEVINE, FIRST SUGGESTED A LEGISLATIVE CHANGE IN THE FORMULA BY WHICH THE GOVERNMENT CONTRIBUTION TO HEALTH PREMIUMS IS CALCULATED.

AS YOU KNOW, THE GOVERNMENT CONTRIBUTION IS 60% OF THE AVERAGE OF PREMIUMS OF SIX CARRIERS SPECIFIED IN FEHBA. THESE CARRIERS ARE KNOWN AS THE BIG SIX AND INCLUDE BLUE CROSS, AETNA, THE TWO LARGEST HMO'S AND THE TWO EMPLOYEE ORGANIZATION PLANS WITH THE LARGEST ENROLLMENTS. IN 1981 THE BIG SIX CHARGED THE FOLLOWING PREMIUMS PER PAY PERIOD FOR FAMILY COVERAGE:

BLUE CROSS/BLUE SHIELD	\$66.16
AETNA	\$50.75
KAISER OF NORTHERN CALIFORNIA	\$50.35
KAISER OF SOUTHERN CALIFORNIA	\$65.71
APWU	\$61.10
NATIONAL ASSOCIATION OF LETTER CARRIERS	\$62.87

OF THE BIG SIX CARRIERS, THREE HAD HIGHER PREMIUMS THAN APWU.

Mr. Devine informed me that OPM would save \$150 million if APWU were out of the Big Six. The third largest employee organization plan has a lower premium plan, which would considerably reduce the premium average of the Big Six. Mr. Devine indicated that he needed to save \$150 million and the only way to accomplish that would be to remove APWU from the Big Six. He further stated that APWU's only solution would be to secure legislation taking APWU out of the Big Six. The non-legislative solution, termination of APWU's health plan, would leave the half-million beneficiaries of the APWU plan without their health plan. Those with medical conditions might be unable to secure other insurance, and some claims from 1981 would be left unpaid, with the union, and perhaps its members individually, liable for the debts. Termination of the plan at the present time, due to the unusual short term deficit in the system, would bankrupt the largest postal employees union in the world.

In addition, termination would force over 212,000 enrollees to switch plans during OPM's "open season". Even in the best of years open season works poorly. Dumping over 200,000 more people on to a federal health insurance market which will already be glutted by enrollees attempting to protect themselves from OPM's new policies, will convert open season into utter chaos. Under the circumstances, I have no doubt that many enrollees will ultimately be left unprotected due to their own lack of information and inevitable bureaucratic delays.

Mr. Chairman, I honestly do not believe that the Director of OPM understood the extent to which he would wreak havoc on retirees, widows, and the entire union membership of the largest postal workers union in the world so he can meet an OMB quota.

I went to the other leaders of Federal Employees Union, and laid out the choices given me by Mr. Devine, termination of

THE APWU PLAN OR LEGISLATION TO REMOVE APWU FROM THE BIG SIX. AT A MEETING OF THE PUBLIC EMPLOYEES DEPARTMENT OF THE AFL-CIO, THE OTHER UNIONS AGREED TO GO ALONG WITH THE LEGISLATION IN ORDER TO SAVE THE APWU. MY STAFF AND I AND OUR REPRESENTATIVES, WITH THE ENDORSEMENT OF THE PED, THEN SOUGHT CONGRESSIONAL SUPPORT FOR SUCH LEGISLATION.

IN THE INTERIM, I CONTACTED MR. DEVINE TO INFORM HIM OF THE ACTION TAKEN BY THE PED, AFL-CIO. HE REQUESTED THAT WE MEET AT 2 P.M. ON OCTOBER 14, AND STATED THAT HE WOULD HAVE A HEALTH PLAN PACKAGE FOR ME AT THAT TIME. AT THAT OCTOBER 14 MEETING MR. DEVINE TOLD ME THAT HE NEEDED TO SAVE MUCH MORE THAN COULD BE SAVED BY TAKING APWU OUT OF THE BIG SIX AND THAT HE WOULD NOW NEED LEGISLATION REMOVING BOTH APWU AND THE LETTER CARRIERS FROM THE BIG SIX, TO BE REPLACED WITH THE THIRD AND FOURTH LARGEST EMPLOYEE ORGANIZATION PLANS, WHICH HAPPEN TO BE LOWER PREMIUM PLANS.

AT THE OCTOBER 14 MEETING, MR. DEVINE SHOWED ME A NEW LOW OPTION PLAN WITH A \$30 PREMIUM TO REPLACE APWU'S CURRENT HIGH OPTION PLAN WHICH HAS A PREMIUM OF \$61.10. APWU HOSPITAL PLAN BOARD MEMBERS, OUR ACTUARIES, AND OUR ATTORNEYS MET IN ALL DAY SESSIONS ON THURSDAY AND FRIDAY TO ANALYZE THE EFFECT OF OPM'S \$30 PREMIUM COUNTER PROPOSAL.

IT IS UNREASONABLE TO EXPECT POSTAL AND FEDERAL EMPLOYEES WHO HAVE CHOSEN A HIGH OPTION/HIGH PREMIUM PLAN TO ACCEPT SUCH A LOW OPTION PLAN. UNDER OPM'S PLAN, APWU WOULD EXPECT TO LOSE AT LEAST ONE-HALF OF ITS ENROLLEES THE FIRST YEAR. WITH A 50% LOSS IN ENROLLMENT, THE APWU PLAN WOULD RUN OUT OF CASH IN MARCH 1982. THERE WOULD BE A SIX MONTHS BACKLOG IN BENEFIT PAYMENTS BY MAY 1982, AND A 5 TO 6 MONTH BACKLOG WOULD PERSIST THROUGHOUT THE REMAINDER OF 1982. ATTACHED TO MY TESTIMONY ARE ACTUARIAL TABLES WHICH DEMONSTRATE THE CASH FLOW PROBLEMS THAT WOULD BE CREATED BY THE OPM PROPOSAL.

IN ADDITION, WITH ONLY A \$30 PREMIUM, APWU WOULD BE UNABLE TO REDUCE ITS DEFICIT OF \$45 MILLION - A DEFICIT THAT WILL BE ELIMINATED BY THE END OF 1982 IF WE ENTER A CONTRACT WITH OPM MEETING THE EQUIVALENCY REQUIREMENTS IMPOSED BY OPM ON ALL THE CARRIERS. WE WOULD ALSO BE ABLE TO BUILD A STRONG CASH RESERVE BY THE END OF 1983.

TABLE II
RESERVE 1982 AND 1983*

	APWU EQUIVALENCY PLAN OF SEPTEMBER 28, 1981	OPM COUNTER PROPOSAL OF OCTOBER 14, 1981
1982		
JANUARY	-\$41 MILLION	-\$45 MILLION
JUNE	-\$21 MILLION	-\$45 MILLION
DECEMBER	+\$ 3 MILLION	-\$45 MILLION
1983		
JANUARY	\$ 7 MILLION	-\$45 MILLION
JUNE	\$27 MILLION	-\$45 MILLION
DECEMBER	\$51 MILLION	-\$45 MILLION

*ASSUMING 1981 YEAR END DEFICIT OF \$45 MILLION

ADMINISTRATIVE COSTS OF THE OPM COUNTER PROPOSAL WOULD ALSO BE PROHIBITIVE. THE TOTALLY DIFFERENT STRUCTURE OF THE OPM COUNTER PROPOSAL WOULD RENDER 90 PERCENT OF EXISTING PROGRAMMING UNUSABLE. NEW SOFTWARE TO REPROGRAM THE DATA BASE, ACCOUNTING CONTROL AND OTHER COMPUTERIZED OPERATIONS, ADDITIONAL COMPUTER CAPACITY, WHICH WOULD BE NECESSARY SINCE EXISTING PROGRAM WOULD HAVE TO BE MAINTAINED UNTIL ALL 1981 CLAIMS WERE PAID, AT THE SAME TIME NEW PROGRAMS TO HANDLE 1982 WOULD HAVE TO GO ON LINE, AND RETRAINING OF PROCESSORS AND OTHER

HEALTH PLAN STAFF WOULD POSE AN ENORMOUS ADMINISTRATIVE COST ON THE PLAN.

IT WAS IMPOSSIBLE FOR THE APWU TO ACCEPT THIS LOW OPTION PLAN, BECAUSE IT WOULD CREATE ENORMOUS CASH FLOW PROBLEMS AND CREATE A LARGE BACKLOG IN CLAIMS PAYMENT DUE TO CASH FLOW PROBLEMS; AND BECAUSE IT WOULD BE IMPOSSIBLE TO ADMINISTER THE CHANGE FROM THE OLD TO THE NEW PLAN. FOR THESE REASONS, I HAD NO CHOICE BUT TO NOTIFY MR. DEVINE THAT APWU COULD NOT, UNDER ANY CIRCUMSTANCES, ACCEPT THE LOW OPTION PLAN BECAUSE IT WOULD DESTROY THE HOSPITAL PLAN AND THE UNION.

MR. DEVINE THEN STATED THAT, SINCE HE HAD TO SAVE A MUCH LARGER SUM OF MONEY, IT WOULD BE NECESSARY TO SEEK LEGISLATION REMOVING BOTH OF THE TWO LARGEST UNION HEALTH PLANS FROM THE BIG SIX. HE HAD RAISED THE SAME POSSIBILITY THE DAY BEFORE. I HAD TOLD HIM THAT THE PROPOSAL DID NOT LOOK PROMISING, BUT THAT I WOULD ATTEMPT TO DETERMINE WHETHER IT COULD OBTAIN SUBSTANTIAL SUPPORT. I THEN ADVISED MR. DEVINE THAT IT DID NOT APPEAR THAT UNION SUPPORT COULD BE OBTAINED. MR. DEVINE THEN ADVISED ME THAT, IF HE DID NOT OBTAIN LEGISLATION REMOVING APWU AND THE LETTER CARRIERS FROM THE BIG SIX, THAT HE WOULD HAVE TO RENEGOTIATE OPM'S CONTRACTS WITH ALL THE OTHER CARRIERS. MOREOVER, THEY WOULD EITHER HAVE TO INCREASE PREMIUMS OR REDUCE BENEFITS.

APWU HAS A PROPOSAL PENDING BEFORE OPM WHICH IS ACTUARIALLY EQUIVALENT TO OPM'S REQUIRED BENEFIT CHANGES, AND WHICH IS FINANCIALLY VIABLE AND WILL LEAD TO ELIMINATION OF APWU'S DEFICIT. APWU HAS TRIED TO COOPERATE WITH OPM, AND WE HAVE GAINED SUPPORT FOR REMOVING APWU FROM THE BIG SIX. THIS SOLUTION IS ACCEPTABLE TO ALL, AND ALLOWS OPM TO SAVE FUNDS AND AT THE SAME TIME TO APPROVE THE APWU PLAN WHICH IS IN THE INTEREST OF ITS MEMBERS.

THERE IS NO POINT IN TERMINATING APWU'S PLAN. NO MORE SAVINGS WILL ACCRUE TO OPM THAN WOULD BE GAINED BY LEGISLATION REMOVING APWU FROM THE BIG SIX. TERMINATING APWU'S PLAN WOULD CAUSE HARDSHIPS FOR THE MORE THAN ONE-HALF MILLION BENEFICIARIES OF THE PLAN AND WOULD CAUSE TURMOIL WITH THE POSTAL SERVICE.

MR. CHAIRMAN, I WOULD LIKE TO BRIEFLY SUMMARIZE THE APWU POSITION.

- 1) APWU HAS BEEN AN APPROVED CARRIER UNDER FEHBA SINCE THE LEGISLATION WAS IMPLEMENTED IN 1960. OUR HISTORY AS A HEALTH INSURER TO POSTAL WORKERS PREDATES FEHBA BY 13-14 YEARS.
- 2) APWU HAS A HISTORY OF FINANCIAL STABILITY.
- 3) AN UNUSUAL SHORT TERM DEFICIT EXISTS IN THE SYSTEM AT PRESENT DUE TO INFLATION AND UNEXPECTEDLY HIGH UTILIZATION RATES.
- 4) THE DEFICIT CAN BE MADE UP IN ONE YEAR UNDER APWU'S EQUIVALENCY PLAN.
- 5) MR. DEVINE'S EFFORTS TO MEET A BUDGET QUOTA HAVE RESULTED IN PROPOSALS - EITHER TERMINATION OF THE APWU PLAN, OR ADOPTION OF A LOW OPTION PLAN WHICH WOULD FAIL- WHICH WOULD UNNECESSARILY DESTROY THE PLAN AND THE UNION.
- 6) MR. DEVINE'S ORIGINAL PROPOSAL TO LEGISLATE APWU ONLY OUT OF THE BIG SIX AND TO APPROVE APWU'S EQUIVALENCY PLAN WOULD HAVE NO ADVERSE IMPACT ON THE BUDGET. IT IS SUPPORTED BY THE APWU AND ALL OTHER PUBLIC EMPLOYEE UNIONS AS A REASONABLE COMPROMISE AND THE PASSAGE OF SUCH LEGISLATION IS, THEREFORE, AN APPROPRIATE SOLUTION FOR ALL PARTIES INVOLVED.

IN CLOSING, I WOULD LIKE TO THANK YOU AGAIN MR. CHAIRMAN FOR CALLING THIS HEARING. THE EVENTUAL FATE OF THE APWU'S HEALTH PLAN WILL HAVE ENORMOUS IMPACT, NOT ONLY ON THE FUTURE OF OUR UNION, BUT ALSO ON THE LIVES AND WELL BEING OF ALL APWU MEMBERS AND PLAN ENROLLEES. THERE IS ABSOLUTELY NO REASON WHY THE INTERESTS AND WELFARE OF THESE PEOPLE CANNOT BE ACCOMMODATED.

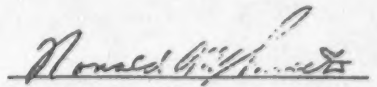
ATTACHMENT A

COMMENTS OF THE APWU HEALTH PLAN'S ACTUARIAL CONSULTANT AND
MANAGEMENT CONSULTANT

October 1, 1981

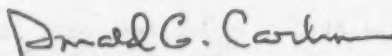
Actuarial and Financial

- o The attached projection shows that the Plan will attain the one month special reserve objective within 2 years as a result of the proposed 15% rate increase and benefit reduction. The changes will place the Plan in a positive special reserve position by the end of 1982. The projection of finances understates the probable improvement in the Plan's actuarial condition since no credit is taken for the utilization decrease that will result from introduction of deductibles and co-insurance.
- o The APWU Plan has a proven record of close adherence to the one month special reserve objective until the unexpected utilization changes of the last 2 years.
- o The APWU Plan has cash available to finance a 4 week reduction in the 12-14 week claims backlog. The proposed 1982 benefit reduction and 15% premium increase is sufficient to finance a further backlog reduction to a 4 week level by October 1982, and permit current payment of claims before the end of 1982.
- o The APWU Plan implemented a 35% premium increase in 1975 without significant effect on enrollment. A decrease of one-third in enrollment would lengthen the period of time to reach current payment of claims by no more than 6 months and attainment of the special reserve objective by no more than 1 year.


Ronald J. Smith
Gabriel, Roeder, Smith & Co.

Operations and Management

- o In June of this year we were retained by the Plan, principally to help solve the Plan's claims backlog problem, and secondarily to help strengthen the Plan's organization and management expertise.
- o We completed our work in early September and recommended significant operations and organization improvements together with substantial cost savings.
- o Implementation of the initial recommendations started in August. Full implementation will be phased over the next several months.
- o Operations improvements and cost savings are visible already. Full implementation of the recommendations should, in our professional judgment, put the Plan in a sound operating position at a reasonably competitive level of administrative expense.
- o And we see no reason why Plan management could not or would not fully implement the recommendations. For example, the claims backlog is being selectively reduced now, and the Plan should be able to attain its targeted 4 to 5 week claims payment cycle by the end of 1982 with less than a 15% premium increase (given the validity of the assumptions used and adoption of the planned benefit reductions).



Donald G. Carlson
Vice President
Booz, Allen & Hamilton, Inc.

PROJECTED IMPACT OF REPRESENTATIVE 1982 PREMIUM INCREASES

AND BENEFIT REDUCTIONS *

1982 PREMIUM INCREASE \$	PROJECTED 1982 AGGREGATE ANNUAL PREMIUM INCREASE	PROPOSED BENEFIT REDUCTION	PROJECTED YEAR-END SPECIAL RESERVE POSITION	
			1981	1982
	(\$ MILLION)	(\$ MILLION	(\$ MILLION)	(MONTHS)
15	41.6	52.2	(45.0)	7.0
20	55.5	52.2	(45.0)	20.9
25	69.4	52.2	(45.0)	34.8
30	83.3	52.2	(45.0)	48.7
35	97.2	52.2	(45.0)	62.6
40	111.1	52.2	(45.0)	76.5
44	122.2	52.2	(45.0)	87.6

29

* PROJECTED BY GABRIEL, ROEDER, SMITH & CO., THE PLAN'S ACTUARY

ATTACHMENT B

(2) United States of America
Office of
Personnel Management

Washington, D.C. 20415

In Reply Refer To

CCE

Morris Biller, General
President
American Postal Workers
Union, AFL-CIO
817 14th Street, NW
Washington, DC 20003

Dear Mr. Biller:

This is our reminder about benefit and premium proposals for your health benefits plan for the contract term beginning January 1, 1982.

Deadline Dates

Deadline dates for 1982 benefit and premium rate proposals are April 30, 1981 for benefit proposals and July 31, 1981 for rate proposals. No extension beyond these dates can be granted, and we will not consider any proposals received after the deadline dates.

Negotiation for new benefits will be carried out during May and June 1981, and all negotiation should be complete on June 30, 1981.

Benefit Changes

Our objective for 1982 is to hold premiums and costs as low as possible. We will, of course, consider any benefit proposals but are likely to accept only (1) those for perfecting changes that are intended to remedy inequitable situations, and result in no, or only minimal, additional premium charges, and (2) those that hold premium charges down through "trade-offs"--reduction in, or elimination of, current benefits of equivalent cost and value--in exchange for new or improved benefits for which there has been a demonstrated need. For community-rated plans, proposals should clearly state whether the benefits will be included in the community rate or in a rider to the community rate.

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Proposals for benefit changes should be specifically and precisely described and supported by your best estimate of their impact on premium, specifically showing any biweekly net-to-carrier premium increase necessary to pay for them. Please submit proposed brochure language with your benefit proposals, including language for the "How Benefits Change in January 1982" page.

Premium Rates

Specific instructions about rate submissions will be provided later.

Kinds of Benefits

There are two benefits that OPM is interested in for 1982. The first area is for hospice care. We realize that much of the care rendered terminally ill patients is convalescent care and maintenance care not normally covered under our present contract with you. We would like to review any proposals for care of the terminally ill in hospices, including cost estimates. A modified or limited benefit would serve as the best vehicle for exploring this area.

Secondly, we want to remind all carriers that we are interested in benefits for dental care. However, any proposals for new dental benefits, or for improvement of existing dental provisions, are subject to the limitations on benefit negotiations set forth above. In addition, we will not accept offsetting reductions in other benefits in order to get dental packages, if such reductions sacrifice the overall ability of your plan to provide a good comprehensive benefit package.

Alternatives to One Year Open Season Cycle

We would like your specific comments on a proposal to conduct Open Season every other year instead of each year, for an estimated savings in both printing/distribution costs and administrative costs, and to give us greater flexibility in managing the Program. In order to reduce the frequency of Open Season, we recognize that a periodic (yearly) adjustment to premium rates must still be made. A "two year cycle" could be accomplished with two year contracts with provision for adjustments in rates after the first year, or two one year contracts with no re-negotiation of benefit provisions but with rate adjustments as is now done.

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Changes in 1981 Open Season Material

Our evaluation of the 1980 Open Season supports the need and desire for material other than brochures for use by employees in comparing plans and making an informed choice. But 1980 raised some questions about the effectiveness and range of use of the comparison charts and summary sheets. We are now making some changes in what we did last year that will improve the material itself and will improve the distribution of all material. You will receive further information about Open Season material and the way it is distributed in the near future.

Disclosure Policy under Freedom of Information

Any information included in your benefit and rate proposal letters is subject to public disclosure after negotiations with all carriers are completed and new benefits and rates are announced. Please identify each item in your benefit and rate proposal letter that you believe is exempt from disclosure under the Freedom of Information Act. Also specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure only when request for information is made. In making our decision, we will consider the justification for non-disclosure submitted with your proposal letters. If we decide that any specific item of information contained in your benefit or rate proposals, that you state you believe is exempt, is not exempt for disclosure, we will so inform you before we disclose.

Cost Management

As in the past, we expect you to continue efforts to contain or reduce costs. Your efforts should not only be in the area of cost containment--carefully monitoring claims and services to eliminate any fraud or abuse, and to pay for, or provide, only those services and supplies covered under our contract with you--but also include efforts to reduce administrative expense where possible and to pursue, or propose, benefits or policies that will result in real savings in Program costs without similar loss of service or care to the patient. Examples of such a benefit or policy would be concurrent review of inpatient hospital stays, and second surgical opinions.

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APR 2 1982

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In addition to these traditional cost containment measures, the Office of Personnel Management is very interested in other ways real savings can be accomplished in the Program. Such ideas may involve restructuring plan benefits or may involve a direct incentive to employees to reduce claims, including experimental proposals that incorporate the concept of "set aside" funds or "refunds" as an incentive to reduced claims experience either through the employee absorbing small expenses out-of-pocket or by the employee's improved health awareness.

Issues Affecting Your Plan

To reflect use of the NAIC Guidelines on coordination of benefits, we suggest the following wording be added to the double coverage provision:

"The Double Coverage limitation is administered in accordance with the National Association of Insurance Commissioners Coordination of Benefit guidelines."

Please review your membership requirements language on the back cover of your brochure and submit any clarifying wording as necessary.

Sincerely yours,

Kevin J. Burns
Assistant Director for
Insurance Programs

cc: Mr. Ben Evans

United States of America
**Office of
Personnel Management**

JUL 16 1981
Washington, D.C. 20415

In Reply Refer To
CNE

Your Reference:

Mr. Morris Biller
General President
American Postal Workers Union, AFL-CIO
Post Office Box 967
Silver Spring, Maryland 20910

Dear Mr. Biller:

We have received your letter of April 27, 1981, proposing benefit changes for the American Postal Workers Union Plan for the 1982 contract term.

We believe the addition of adult dental care benefits is a definite program enhancement. However, owing to cost considerations, we are unable to approve the proposals. In order to generate sufficient savings to offset the increased costs associated with the adult dental care benefit and to enable us to approve the proposed benefit changes, we would like to counterpropose the following:

- 1) Introduce a \$40 per family member calendar year deductible. After the deductible is met, pay doctors' visits at 100 percent. Pay at 80 percent charges for prescription drugs, appliances, medical supplies, and physical, occupational and speech therapies.
- 2) Introduce a 60 day limitation for in-hospital confinements resulting from mental and nervous conditions, alcoholism and drug addiction.
- 3) Introduce a Catastrophic Protection Benefit allowing the Plan to pay 100 percent of covered expenses after all deductibles are met and out-of-pocket expenses under Other Medical Benefits reach \$1,000.

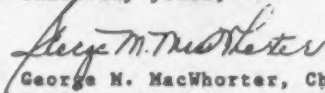
Proposals are under consideration by the United States Congress to have Medicare become the second payer for individuals who are enrolled in the Federal Employees Health Benefits Program. If the Program becomes primary, we will work with the Plan to accommodate the necessary adjustments in coverage and premium.

JUL 16 1981

We also anticipate specific action by the Congress again this year to prohibit abortions under the FEHB program. If such prohibition is enacted, it may be necessary to alter the Plan's abortion coverage.

If these counterproposals are agreeable with you, we will appreciate your written acceptance so that benefit changes may be incorporated into the Plan's 1982 brochure.

Sincerely yours,



George M. MacWhorter, Chief
Employee Organization Plans Division
Insurance Programs

cc: Mr. Benton Evans
Darryl J. Anderson, Esquire



American Postal Workers Union, AFL-CIO

HOSPITAL PLAN DEPARTMENT

P. O. Box 967, Silver Spring, Maryland 20910

July 23, 1981

Mr. George M. MacWhorter, Chief
Employee Organization Plans Div.,
Insurance Programs
Office of Personnel Management
P.O. Box 707
Washington, D.C. 20006

Dear Mr. MacWhorter:

This is with reference to your letter to President Biller reflecting your counter proposal on benefits for the contract year of 1982 for American Postal Workers Union, AFL-CIO.

Please be advised, President Biller has authorized me to accept your counter proposals. Attached please find a copy of the benefit proposals as agreed by the American Postal Workers Union and the Office of Personnel Management. Also, in compliance with your letter you may proceed with the wording of the brochure for 1982.

With kind regards,

Sincerely yours,

BE:sm
opeiu #2
afl-cio

BEN EVANS
Director

cc: Mr. Moe Biller, General President, APWU, AFL-CIO



United States
Office of
Personnel Management

ATTACHMENT C

Washington, D.C. 20415

Morris Biller, General
President
American Postal Workers
Union, AFL-CIO
817 14th Street, NW
Washington, DC 20005



Your Reference

Dear Mr. Biller:

This is in further reference to our benefit and rate negotiations for 1982.

As explained in Director Devine's preliminary analysis of the Federal Employees Health Benefits Program, we will consider equivalency proposals from carriers. Equivalency proposals are defined as those which include benefit reductions equal in cost savings to those which OPM proposed to you at our August 21 meeting - \$200 deductible; 75% coinsurance; and placement of most non-hospital charges under supplemental benefits.

To enable us to consider equivalency proposals, we need: 1) your actuarial evaluation of cost savings based on the August 21 proposal; 2) your benefit equivalency proposal; 3) your actuarial evaluation of cost savings for the equivalency proposal; and 4) actuarial supporting documentation for your rating of our proposal and your equivalency proposal. This must be submitted no later than September 25, 1981.

If you have any questions, please contact me.

Sincerely yours,

George M. MacWhorter
George M. MacWhorter, Chief
Employee Organization Plans Division
Insurance Programs

cc: Mr. Ben Evans
Mr. Williams J. Kaczor
Mr. Francis J. Kowalczyk
Mr. Darryl J. Anderson, Esquire

ATTACHMENT D

CASH FLOW '82 ASSUMING NO LOSS OF MEMBERSHIP

	<u>Payments</u>	<u>Income</u>	<u>Cash</u>
Jan.	25.3	21.9	21.6
Feb.	25.3	10.	6.3
March	26.0	13.05	(6.65)
April	21.0	10.5	(17.15)
May	18.0	10.5	(24.65)
June	14.0	21.25	(17.4)
July	12.0	10.5	(18.90)
Aug.	11.9	10.5	(20.30)
Sept.	11.8	15.6	(16.50)
Oct.	11.6	10.5	(17.60)
Nov.	11.5	10.5	(18.60)
Dec.	11.3	10.5	(19.40)

2 months backlog + \$45 million deficit

CASH FLOW '82 - ASSUMING 50% OF MEMBERSHIP

	<u>Payments</u>	<u>Income</u>	<u>Cash</u>
Dec. 31			25.
Jan.	25.3	21.9	21.6
Feb.	25.3	5.	1.3
March	23.3	7.8	(14.2)
April	16.5	5.25	(25.45)
May	12.5	5.25	(32.7)
June	8.5	16.	(25.2) (5 mo. backlog)
July	6.5	5.25	(26.45)
Aug.	6.4	5.25	(27.60)
Sept.	6.3	7.80	(26.10)
Oct.	6.1	5.25	(26.95)
Nov.	6.	5.25	(27.70)
Dec.	5.8	5.25	(28.25)

5 - 6 months backlog + \$45 million deficit

APPENDIX

Summary of Legislative History
Concerning OPM's Authority Under FEHBA

OPM Has Never Had The Authority To Insist That
Federal And Postal Employees Health Benefits
Be Cut.

When the Federal Employees Health Benefits Act (FEHBA) was passed in 1959, it established maximum and minimum limitations, in dollars, on Government contributions for employee health benefits. The Civil Service Commission (hereinafter OPM) was given the authority to negotiate with prospective FEHBA carriers to obtain contracts which "for the premium agreed upon [offered] the best possible basic health and major medical benefits." H. Rep. No. 957, 86th Cong., 1st Sess. (1959); 1959 U. S. Code Cong. & Admin. News, at 2916; See also S. Rep. No. 468, 86th Cong., 1st Sess. (1959), at 15.

Under 5 U.S.C. 8902(d), OPM was given authority to negotiate with carriers for contracts that included "such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desireable." OPM was purposely restricted, however, from driving benefits below the dollar floor set by Congress as the minimum government contribution. In fact, the Floor on Government contributions was established by the House Committee in part because OPM had claimed it would have the right, under the Senate-passed bill, to contract for any level of benefits it deemed desireable.

As Chairman Murray of the House Committee on Post Office and Civil Service explained, the minimum Government contribution was established to insure the provision of adequate insurance protection for Federal employees. See 105 Cong. Rec. 17552-53 (1959).

Thus, under the 1959 Act, OPM had the discretion to contract for benefits it deemed necessary or desirable, within a dollar range of Government contributions set by Congress. Its authority to pick and choose among benefit packages offered by carriers was written broadly because FEHBA was a new program, and Congress wanted to purchase the best possible benefits for Federal employees for the authorized Federal expenditure. But Congress specifically restricted OPM's authority to cut benefits in order to save money.

By 1970, it was clear to Congress that the establishment of specific dollar levels of Government contributions inevitably resulted in inadequate contributions, because of incessant increases in the cost of health care. Even in 1960, the Government contribution was only 38 percent of aggregate employee health insurance premiums, although Congress had intended to set a rate of approximately 50 percent. Despite a 1966 increase in the Government contribution it had fallen to only 24 percent of aggregate premiums by 1970. H. Rep. No 1084, 91st Cong., 2nd Sess. (1970); 1970 U.S. Code Cong. & Admin. News, at 3868-69.

To prevent this constant erosion of the Government contribution, Congress eliminated the ceiling on Government contributions and left only a floor. That floor was established as

40 percent of the premiums charged by the so-called "big six" carriers for their highest level of benefits.

When this formula was adopted by Congress, it was absolutely clear to them that they were adopting a formula which would result in automatically increasing the Government contribution for employee health benefits insurance every year, as health costs increased. In fact, Congress acted because it recognized that constantly rising costs eroded the value of any fixed-dollar Government contribution on a regular basis. Congress saw this automatic increase mechanism as a distinct improvement, because it would increase benefits yearly as costs rose. E.g., H. Rep. No. 1084, supra; 1970 U.S. Code, Congressional and Administrative News 3866, 3870; 116 Cong. Rec. 23535, 28536.

The Administration opposed the 1970 amendments because it recognized that their effect was to deny OPM any authority to prevent the continued increase in Government contributions. Letter From Civil Service Commission Chairman Hampton to Senate Committee Chairman McGee, dated April 28, 1969; S. Rep. No. 1151, 91st Cong., 2nd Sess. (1970), at 4. Congress and the Administration recognized the fact that the only brake on premiums would be the fact that employees who enrolled in plans more expensive than the big six average would have to pay the additional cost of premiums themselves. Id., at 7. OPM was given no new authority to cut costs by insisting on benefit cuts, and it acknowledged that it had no such authority.



Mail Handlers Health Benefit Plan

Suite 290 North • 1800 M Street, N.W. • Washington, D.C. 20036 • (202) 223-3300

MEMORANDUM

October 16, 1981

To: William B. Welsh, Staff Director
Committee on Post Office and Civil Service
309 Cannon House Office Building
Washington, D.C. 20515

Jamie Cowen, Esq., Chief Counsel
Subcommittee on Civil Service, Post Office
and General Services
Capitol Hill Apartments
125 C Street, N.E. - Room 57
Washington, D.C. 20510

From: James J. LaPenta, Jr., Director
Mail Handlers Health Benefit Plan

Subject: Office of Personnel Management Proposed Regulations

Attached is the material that I promised to send to you in our telephone conversations Thursday and Friday. In summary, we and the other signatory unions are objecting to the OPM regulations for the following reasons:

1. Proposed regulations do not reflect past OPM/CSC practices or insurance industry practices.
2. Proposed regulations will lock in place administrative costs disputes that are subject of legitimate controversy.
3. Community rated plans are excluded from these regulations without any legitimate or legal basis, thereby creating an anti-competitive situation. This causes a competitive injury to employee organizations.

To: William B. Walsh
Jamie Cowen, Esq.
From: James J. LaPenta, Jr.

October 16, 1981
Page 2

4. Proposed regulations do not recognize that employee organizations are bona fide nonprofit organizations.
5. Proposed regulations on less than 10 percent of the costs instead other 90 percent over \$2 billion per annum.
6. Proposed regulations will add costs without adding efficiency to the administration of the program.
7. Proposed regulations do not provide for cost containment.

In the attached package is a copy of the OPM proposed rulemaking that appeared in the Federal Register, Vol. 46, No. 132, Friday, July 10, 1981; our cover letter to OPM dated August 13, 1981; and our section-by-section comments to these proposed regulations.

The Court has given OPM an extension to October 20, 1981.

I, along with my insurance attorney and my government contract attorney, are scheduled to set up a meeting with you next week.

You should advise Dr. Devine that you are taking a look at his proposed regulations and ask that you be given an opportunity to review them in detail before he publishes them.

Encls.

Dated: May 23, 1981.
 William W. Rice,
 Acting Regional Administrator.
 (FR Doc. 81-2623 Filed 7-9-81; 840 (a))
 BILLING CODE 5000-20-01

OFFICE OF PERSONNEL MANAGEMENT

41 CFR Chapter 101

Procurement Regulations

AGENCY: Office of Personnel
Management.

ACTION: Proposed rulemaking.

SUMMARY: The Office of Personnel Management is proposing procurement regulations which will apply to the negotiation and administration of contracts between OPM and carriers for Federal Employees Health Benefits (FEHB) plans. These regulations will provide direction and uniformity in the agency's procurement of health coverage and will also enable the health benefits carriers and other interested parties to understand the application of the Federal Procurement Regulations (41 CFR Chapter 1) to the FEHB Program contracts.

DATE: Comments must be received on or before August 10, 1981.

ADDRESS: Send or deliver written comments to Mr. Craig B. Pettibone, Director, Office of Pay and Benefits Policy, Compensation Group, Office of Personnel Management, Room 4351, Washington, D.C. 20415.

FOR FURTHER INFORMATION CONTACT: Mary Ann Mercer, 202-632-4634 or 202-354-0900.

SUPPLEMENTARY INFORMATION: On January 21, 1981, the Office of Personnel Management published an Advance Notice of Proposed Rulemaking in the Federal Register (46 FR 6022-6025) concerning the proposed procurement regulations which it intends to apply to the negotiation and administration of the Federal Employees Health Benefits (FEHB) Program contracts.

OPM's procurement regulations are issued in response to an order issued by the United States District Court for the District of Columbia in the case of *National Treasury Employees Union v. Campbell*, Civil Action No. 75-2173, issued September 18, 1980, which instructed OPM to publish procurement regulations for its Government-wide Service Benefit Plan. Background on the FEHB Program and the facts leading to the issuance of the court order are detailed in the Advance Notice referenced above. The Federal Procurement Regulations (FPR), 41 CFR

Chapter 1, have been promulgated by the General Services Administration to ensure uniformity in procurement by the Federal Government. Consequently, OPM anticipates applying its procurement regulations to all of the FEHB contracts, not solely to the Government-wide Service Benefit Plan. The regulations have been drafted to identify for all FEHB carriers which provisions of the Federal Procurement Regulations OPM considers to have practical application to FEHB contracts. The proposed regulations are intended to simply state in regulatory form what has long been our administrative practice in contracting with health benefits carriers for health benefits plans. No substantive changes are intended in the way in which we administer the health benefits program.

Although 5 U.S.C. 552(a)(2) exempts procurement regulations from the necessity of being published as proposed rulemaking, OPM believes that comments from the public are mutually beneficial in drafting the regulations. The 60-day public comment period for the Advance Notice of Proposed Rulemaking expired March 23, 1981. In response to the Advance Notice, OPM received comments from the two Government-wide plans, five comprehensive plans, one national association of health maintenance organizations, ten employee organizations, two government agencies, one quasi-government agency, and one member of the general public. Of the 22 comments received, 17 were generally favorable and five were unfavorable. Because of the numerous points covered in the letters received, only the issues of broadest application will be discussed below.

Four carriers requested an extension of the 60-day public comment period to allow more time to study and analyze the extensive FPR and its impact on the administration of their FEHB contracts. OPM is unable to extend the time period allotted in view of the court order to issue the regulations within a limited time frame.

Two carriers indicated that OPM has no clear authority to apply the regulations to all FEHB contracts, since the court order requires that OPM promulgate regulations governing the Government-wide Service Benefit Plan. OPM has always maintained that the FPR applies to its FEHB contracts. OPM further believes that publishing procurement regulations for only one FEHB plan would not only be contrary to the overall intent of the decision of the District Court, which states that "Both Federal employees and

organizations which contract with the government for such plans are entitled, in fairness and under section 1.208 (of the FPR), to the benefit of regulations which will inform them which portions are applicable . . . but would also be contrary to the intent of the FPR to encourage uniformity in the procurement of Government contracts.

Several comments were received indicating that only the regulations authorized by title 5, United States Code, Chapter 89, which are codified at 5 CFR Part 898, need apply to the procurement of FEHB contracts. Section 201 of the Federal Procurement and Administrative Services Act of 1946 (41 U.S.C. 481(a)) provides that the Administrator, General Services Administration (GSA) has the authority to "prescribe policies and methods of procurement and supply of personal property and nonpersonal services, including related functions such as contracting . . ." for executive agencies. Further, 40 U.S.C. 474 provides that the authority conferred by the Act on the Administrator, GSA, to prescribe policies and methods of procurement is "in addition and paramount to any other law and shall not be subject to the provisions of any law inconsistent therewith . . ." The regulations which OPM issues pursuant to 5 U.S.C. 551.3 are OPM's general policies for the administration of the FEHB Program. These general regulations, in accordance with 40 U.S.C. 474, are subordinate to regulations promulgated by the General Services Administration which establish specific policies and procedures for use in the procurement of government contracts.

Three respondents commented that OPM did not offer sufficient guidance in its Advance Notice of Proposed Rulemaking to enable the carriers to know which portions of the FPR apply to FEHB contracts. It was not OPM's intent to address in its Advance Notice all of the details that would be contained in the proposed and final regulations. The intent behind the Advance Notice was to solicit carrier comments so that OPM would be able to take the carriers' concerns into consideration before writing lengthy regulations. In the introduction of the Advance Notice, carriers were advised that more detailed proposed regulations would follow.

Two comments concerned the prospective applicability of the FPR. Since final government regulations require a prospective effective date, the effective date of OPM's procurement regulations implementing the FPR will be prospective. It should be pointed out,

however, that in the absence of OPM implementing regulations, Chapter 1 of the FFR has applied and will continue to apply to FEHBP contracts until the effective date of Chapter 18.

Four respondents expressed concern that OPM may attempt to apply the cost principles contained in Part 1-15.2 of the FFR to community rated contracts. OPM indicated in its Advance Notice that the application of the cost principles in the FFR to community rated contracts is inconsistent with the concept of community rating and the FFR. This interpretation has been specifically stated in the proposed rules so that there will be no misunderstanding that the cost principles will not apply to community rates. Two comments revealed a concern that experience rated carriers are being unfairly discriminated against because the cost principles are being applied by OPM only to experience rated contracts. OPM disagrees. The FFR recognizes that different levels of government monitoring and regulations should be accorded different types of government contracts. The rule applied by OPM to community rated contracts in Chapter 18 are consistent with the provisions of the FFR.

Four responses suggested that OPM deviate from many of the cost principles required by the FFR thereby distinguishing insurance contractors from other contractors dealing with the Federal Government. The respondents imply that OPM should grant mass deviations for its experience rated contracts. The FFR cost principles are current requirements set out by the General Services Administration (GSA) which are applicable until GSA revises or deletes them. Mass deviations would be tantamount to separate OPM procurement policies. The court order stated that OPM should not issue entirely new regulations, but that OPM should set forth how it would implement the regulations embodied in the FFR. Consequently, to the extent that the cost principles can be applied to experience rated contracts, the provisions will be applied.

Several respondents supported OPM's application of modified contract coverage (Cost Accounting Standards 401 and 402) to FEHBP contracts, but opposed OPM's suggestion that it would attempt to apply all cost Accounting Standards. OPM agrees that only CAS 401 and 402 should be applied to the FEHBP contracts, unless the carrier meets the FFR criteria for full CAS coverage.

It was the opinion of several carriers that the specific factors relevant to the service charge negotiations for

experience rated contracts were vague and difficult to quantify. In the proposed regulations, OPM has attempted to describe how the factors will be utilized in determining the reasonableness of any annual service charge which may be negotiated for experience rated contracts. Associate membership dues charged by an employee organization entitling individuals to join the organization's health plan has been dropped as a factor to be considered by the contracting officer during the service charge negotiations, since several employee organization plans believe, and OPM concurs, that it does not sufficiently relate to the contract.

One comment supported the application of FFR provisions to subcontractors where the subcontractor performs all or part of the prime contract. OPM agrees insofar as experience rated prime contracts are concerned. In the case of the Government-wide Service Benefit Plan, which the respondent specifically referenced, however, the District Court decided that contracts between the physicians and hospitals and the carrier do "not establish a contract-subcontractor relationship." Accordingly, the FFR provisions in question would not apply to those contracts.

One comment was received supporting the application of FFR 1-1.327, "Protection of the privacy of individuals," to FEHBP contracts. This FFR section implements subsection (n) of 5 U.S.C. 552a (Pub. L. 93-579, December 31, 1974), which guards the individual's right of privacy whenever an agency system of records on individuals is operated under contract and not by the agency. FEHBP records systems maintained by health benefits carriers under contract with OPM are not maintained for the purpose of accomplishing an OPM function. It is not now, and never has been, a function of OPM to provide health benefits to Federal employees; OPM's function has been simply to contract for these services from private insurance companies. Insurance company records on individuals serve the companies' own commercial function of paying health benefits claims in return for premiums paid by the Government and the Federal employees and, consequently, are not subject to the record keeping requirements of the Privacy Act and § 1-327 of the FFR. FEHBP contracts will, nevertheless, contain a "Confidentiality of Records" clause which will serve to protect the subscribers right of privacy.

The Director finds that good cause exists for reducing the comment period of this proposed rulemaking from sixty

to thirty days. The comment period is reduced because of a time limitation imposed by the United States District Court for the District of Columbia for the publication of final regulations.

E.O. 12291, Federal Regulation

Under the provisions of Executive Order 12291, certain procedures must be followed by government agencies prior to publication of "major" rulemaking. OPM does not consider its procurement regulations to be "major" since they simply set forth OPM's implementation of previously existing regulations, that is, 41 CFR Chapter 1, and, therefore, are not anticipated to have any significant impact on the economy.

OPM has determined that this is not a major rule for the purposes of E.O. 12291, Federal Regulation, because it will not result in:

- (1) An annual effect on the economy of \$100 million or more;
- (2) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- (3) Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Regulatory Flexibility Act

The Director, Office of Personnel Management, certifies that this regulation will not have a significant economic impact on a substantial number of small entities, including small business, small organizational units and small governmental jurisdictions.

Office of Personnel Management,
Beverly McCain Jones,
Insurance System Manager.

Accordingly, OPM proposes to amend title 41, Code of Federal Regulations by adding Chapter 18 as follows:

SUBTITLE A—FEDERAL PROCUREMENT REGULATIONS SYSTEM

CHAPTER 18—OFFICE OF PERSONNEL MANAGEMENT

- Part
- 18-1 General
 - 18-3 Procurement by negotiation
 - 18-4 Special types and methods of procurement
 - 18-7 Contract clauses
 - 18-8 Termination of contracts
 - 18-11 Federal, State and local taxes
 - 18-12 Labor
 - 18-15 Contract cost principles and procedures

- Part
10-20 Retention requirements for contractor and subcontractor records
10-20 Contract modifications
- PART 10-1—GENERAL**
Sec.
10-1.100 Scope of part.
- Subpart 10-1.1—Regulation System**
10-1.101 Scope of subpart.
10-1.102 Purpose.
10-1.103 Authority.
10-1.104 Relationship of Chapter 10 to the FFR.
10-1.105 Issuance.
10-1.107 Arrangement.
10-1.107-1 General plan.
10-1.107-2 Numbering.
10-1.107-3 Citation.
10-1.107-4 Cross references.
10-1.108 Implementation.
10-1.109 Deviation.
10-1.109-1 Description.
10-1.109-2 Procedure.
10-1.110 Use of designations.
- Subpart 10-1.2—Definition of Terms**
10-1.200 Definitions.
- Subpart 10-1.3—General Policies**
10-1.301 Method of procurement.
10-1.302 Negotiation.
10-1.303 Procurement sources.
10-1.303-1 Who may contract.
10-1.303-2 Contracts between the Government and Government employees or business concerns substantially owned or controlled by Government employees.
10-1.305 Approval signatures.
10-1.312 Records of contract actions.
10-1.314 Disputes.
10-1.320 Subcontractor gifts and kickbacks.
10-1.323 Preferences for U.S. Flag Air Carriers.
10-1.328 Fraudulent claims.
10-1.341 Federal Procurement Data System.
- Subpart 10-1.4—Procurement Responsibility and Authority**
10-1.400 Scope of subpart.
10-1.401 Signature responsibility.
10-1.401-1 Responsibility of the head of the agency.
10-1.401-2 Responsibility of the Associate Director for Compensation.
10-1.402 Responsibility of the contracting officer.
10-1.403 Requirements to be met before entering into contracts.
10-1.404 Selection, designation, and termination of designation of contracting officer.
10-1.405 Ratification of unauthorized contract actions.
10-1.406 Cost accounting standards.
- Subpart 10-1.5—Contingent Fees**
10-1.500 Scope of subpart.
- Subpart 10-1.6—Outsourced, Suspended, and Ineligible Carriers**
10-1.600 Scope of subpart.
10-1.601 Applicability.

- Subpart 10-1.8—Reporting Possible Antitrust Violations**
Sec.
10-1.801 General policy.
- Subpart 10-1.10—Publishing Procurement Actions**
10-1.1001 General policy.
10-1.1002 Synopsis of proposed procurements.
10-1.1004 Synopsis of contract awards.
10-1.110—Responsible Prospective Contractors
10-1.1200 Scope of subpart.
10-1.1201 Applicability.
- Subpart 10-1.22—Environmental Protection**
10-1.2200 Scope of subpart.
Authority: 40 U.S.C. 2001; 5 U.S.C. 5513.
- § 10-1.200 Scope of part.**
This part describes the method by which the Office of Personnel Management (OPM) implements, supplements and deviates from the Federal Procurement Regulations (FFR) (41 CFR Chapter 1) through the establishment of the OPM Procurement Regulations (Chapter 10), which prescribe the Office procurement policies and procedures for the Federal Employees Health Benefits Program (FEHBP) contracts. Policies and procedures governing the award and administration of FEHBP contracts are contained in Part 1 of this Chapter, "Special Types and Methods of Procurement."
- Subpart 10-1.1—Regulation System**
§ 10-1.101 Scope of subpart.
This subpart sets forth introductory information pertaining to Chapter 10, explains its purpose, authority under which it is issued, its relationship to the FFR System, applicability, method of issuance, and arrangement. It also provides procedures for implementing and supplementing the FFR and Chapter 10 and sets forth deviation procedures.
- § 10-1.102 Purpose.**
Chapter 10 is prescribed by the Director, Office of Personnel Management to provide direction and uniformity in the agency's procurement of health coverage under the FEHBP Program.
- § 10-1.103 Authority.**
Chapter 10 is issued under the authority of 5 U.S.C. Chapter 55 and 40 U.S.C. 486(c).
- § 10-1.104 Relationship of Chapter 10 to the FFR.**
(a) The Federal Procurement Regulations set forth in Chapter 1, title 41, of the Code of Federal Regulations are applicable to contracts between the Office of Personnel Management (OPM)

- and health benefits carriers which establish health benefits plans for Federal employees and annuitants. Chapter 10 provides guidance to the contracting officer, health benefit carriers and other interested parties for implementing, supplementing and in certain instances, deviating from the FFR. Except as necessary to assure continuity or understanding, material published in the FFR will not be repeated, paraphrased, or otherwise restated in Chapter 10.
- (b) Implementing material is that which expands upon related FFR material. Supplementing material is that for which there is no counterpart in the FFR.
- (c) Material in Chapter 10 may supersede the FFR as when a deviation (see § 10-1.109-1) is authorized, but only when the deviation contains an explicit cross reference to the FFR.
- (d) In order to make FEHBP carriers fully aware of which portions of the FFR are applicable to contracts with FEHBP, and to establish official OPM policy for internal contract evaluations, all parts of 41 CFR Chapter 1 which are deemed to have practical application to the administration of FEHBP contracts are specifically dealt with in this Chapter 10.
- § 10-1.105 Issuance.**
(a) Policies and procedures which are issued in this Chapter will be published in the Federal Register as Chapter 10 of Title 41 of the Code of Federal Regulations.
- (b) The Federal Register and Title 41 of the Code of Federal Regulations may be purchased by the public from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.
- § 10-1.107 Arrangement.**
§ 10-1.107-1 General plan.
Chapter 10 conforms with the FFR system with respect to divisional arrangements into parts, subparts, sections, subsections, and further subdivisions as necessary.
- § 10-1.107-2 Numbering.**
(a) Generally, the numbering system used in Chapter 10 conforms to that of Chapter 1 (see FFR 1-1.007-2). Thus, a particular procurement policy or procedure is identified by the same number in both Chapter 1 and Chapter 10, except that the first number in Chapter 1 will be 1 rather than 10.
- (b) Where Chapter 10 implements a part, subpart, section or subsection of the FFR, the implementing part, subpart, section or subsection of Chapter 10 is

numbered to correspond to the FPR part, subpart, section or subsection, e.g., § 16-1.107-3 implements § 1-3.607-3 of the FPR. Paragraph and subparagraph designations of Chapter 16, however, are independently developed and do not necessarily correspond to a paragraph or subparagraph of the FPR.

(c) Where Chapter 16 supplements the FPR and thus deals with subject matter not contained in the FPR, the numbers in the group 50 through 99 are assigned to the respective supplementing parts, subparts or sections.

(d) Where the subject matter contained in the part, subpart, section or subsection of the FPR has no practical application at this time to FEHBP contracts, this Chapter 16 contains no corresponding part, subpart, section or subsection. Thus, there are gaps in the Chapter 16 series of part, subpart, section and subsection numbers.

§ 16-1.107-3 Citation.

(a) In formal documents, such as legal briefs, citation of Chapter 16 material which has been published in the Federal Register will be to Title 41 of the Code of Federal Regulations.

(b) Any section of Chapter 16, for purpose of brevity, may be informally identified as "OPMPR" followed by section number. For example, this paragraph would be identified in a memorandum as "OPMPR 16-1.107-3(b)".

§ 16-1.107-4 Cross references.

(a) Within Chapter 16, cross references to the FPR will be made in the same manner as used within the FPR. Illustration of cross references to the FPR are:

(1) Part 1-2.

(2) Subpart 1-3.5.

(3) Section 1-3.607-90(a). The word "section" or its symbol (§) is used in making a cross reference even though the reference may be to a subsection, paragraph or subparagraph. For example, this reference is actually to a paragraph.

(b) Within Chapter 16, cross reference to parts, subparts and sections of Chapter 16 will be in a manner generally similar to that used in making references to the FPR. For example, this paragraph would be referred to as § 16-1.107-4(b).

§ 16-1.108 Implementation.

As portions of the FPR are prescribed, procurement policies and procedures which have practical application to the FPR will be issued in Chapter 16 by the Director, Office of Personnel Management.

§ 16-1.109 Deviation.

§ 16-1.109-1 Description.

(a) The term "deviation" as used in Chapter 16 is defined in the same manner as described in FPR 1-1.009-1.

(b) In order to maintain uniformity to the greatest extent feasible, deviation from the FPR will be kept to a minimum.

§ 16-1.109-2 Procedure.

(a) In individual cases, when the contracting officer considers it necessary to deviate from the policies set forth in the FPR, a request for authority to do so will be submitted to the Director, Office of Personnel Management. The request will clearly set forth the circumstances warranting the deviation and the nature of the deviation.

(b) Deviations in classes of cases must be approved in advance by GSA. Class deviations will be set forth in this Chapter 16 as provided in § 16-1.104(c).

§ 16-1.189 Use of designees.

Throughout the regulations in Chapter 16, responsibilities and duties are assigned to certain individuals by position title, and, in many instances, the submission of reports to and by these individuals is also prescribed. Whenever these titles are used, the individual occupying these positions may, unless otherwise restricted by law or the regulations in 41 CFR Part 800 or this Chapter 16, designate a subordinate to act for him or her.

Subpart 16-1.2—Definition of Terms

§ 16-1.200 Definitions.

Definitions pertaining to this Chapter 16 are contained in Part 16-4, "Special Types and Methods of Procurement."

Subpart 16-1.3—General Policies

§ 16-1.301 Method of procurement.

§ 16-1.301-3 Negotiation.

Use of formal advertising in connection with the award of FEHBP contracts is not determined to be feasible or practicable. Pub. L. 96-362, as amended and codified at 5 U.S.C. Chapter 69, authorizes the negotiation of FEHBP contracts. FEHBP contracts, accordingly, will be negotiated pursuant to the provisions of § 1-3.215 and the authority in 41 U.S.C. 252(c)(16) which permits the negotiation of contracts "otherwise authorized by law."

§ 16-1.302 Procurement sources.

§ 16-1.302-1 Who may contract.

The OPM may contract with health benefits carriers for plans meeting the requirements of 5 U.S.C. Chapter 890, 5

CFR Part 890, and this Chapter 16 for the provision of health coverage.

§ 16-1.302-3 Contracts between the Government and Government employees or business concerns substantially owned or controlled by Government employees.

FPR 1-1.302-3 is applicable to the administration of the FEHBP contracts.

§ 16-1.303 Approval signatures.

FPR 1-1.303 is applicable to the administration of the FEHBP contracts.

§ 16-1.313 Records of contract actions.

FPR 1-1.313 is applicable to the administration of the FEHBP contracts.

§ 16-1.316 Disputes.

FPR 1-1.316 is applicable to FEHBP contracts and the Disputes clause set forth in OPMPR 16-7.502-2 shall be included in all FEHBP contracts.

§ 16-1.320 Subcontractor gifts and kickbacks.

FPR 1-1.320 is applicable to the administration of the FEHBP contracts.

§ 16-1.323 Preference for U.S. Flag Air Carriers.

FPR 1-1.323 is applicable to the administration of the FEHBP contracts.

§ 16-1.326 Fraudulent claims.

FPR 1-1.326 is applicable to the administration of the FEHBP contracts.

§ 16-1.341 Federal Procurement Data System.

The contracting officer shall comply with FPR 1-1.341 set out in Temporary Regulation 48 by submitting Standard Form 278, "Federal Procurement Data Systems Individual Contract Action Report (Over \$10,000)" or Standard Form 281, "Federal Procurement Data System Sum of Contract Actions of \$10,000 or Less and Subcontract Data on Selected Prime Contracts", as appropriate, to the Administrative Services Division, Acquisition Branch, for each procurement action. Procurement actions within the FEHBP take place only during the first quarter of each calendar year.

Subpart 16-1.4—Procurement Responsibility and Authority

§ 16-1.400 Scope of subpart.

This subpart sets forth the authority of the Director, Office of Personnel Management and the designation and authority of the FEHBP contracting officer. It also imposes limitations upon the authority of the contracting officer to enter into contracts.

§ 16-1.401 Signature responsibility.**§ 16-1.401-1 Responsibility of the head of the agency.**

The Director, Office of Personnel Management is responsible for approval of basic policies affecting the administration of the FEHBP law, the issuance of regulations implementing these policies, and final approval of health benefits contracts for the Government-wide Service Benefit Plan and the Government-wide Indemnity Benefit Plan.

§ 16-1.401-2 Responsibility of the Associate Director for Compensation.

The Associate Director for Compensation shall approve: any strategy or plan used in conducting benefit negotiations with FEHBP contractors; deviations from an approved negotiation plan; major issues or controversies arising during negotiations; rate decisions on the Service Benefit Plan, the Indemnity Benefit Plan, and the two employee organization plans with the largest number of enrollments and the two comprehensive plans with the largest number of enrollments; potentially controversial rate changes; major issues arising in the administration of the contracts (e.g., expense allowability issues, carrier enforcement of cost containment provisions, etc.).

§ 16-1.402 Responsibility of the contracting officer.

The Associate Director for Compensation has designated the Assistant Director for Insurance Programs as contracting officer for FEHBP contracts, and has delegated to the Assistant Director for Insurance Programs or his designee the authority to approve health benefits carriers; negotiate and execute health benefits contracts, except that execution of the service benefit and indemnity benefit contracts is reserved to the Director, OPM; administer health benefits contracts, including the authority to direct payment of disputed health benefits claims; conduct an audit program for health benefits contracts, including the authority to allow the costs involved in disputed audit findings (not to be reimbursed), except that the latter authority is reserved to the Associate Director for Compensation with respect to disputed costs in excess of \$100,000 and, in the Service Benefit Plan, OPM, with respect to disputed costs in excess of \$50,000. In the absence of the contracting officer or his designee, the Assistant Director for Insurance Programs is authorized to execute the requirements of FPR 1-1.402 and 1-1.403.

Federal Procurement Regulations, imposed by the OPM.**§ 16-1.403 Requirements to be met before entering into contracts.**

No contract shall be entered into unless all applicable requirements of law, Executive orders and regulations have been met. The term "regulations" includes those issued by any regulatory agency whether or not incorporated or referenced in the Federal Procurement Regulations.

§ 16-1.404 Selection, designation, and termination of designation of contracting officer.

FPR 1-1.404 is applicable to the administration of the FEHBP contracts.

§ 16-1.406 Authentication of unauthorized contract awards.

FPR 1-1.406 is applicable to the administration of the FEHBP contracts.

§ 16-1.408 Cost accounting standards.

FPR 1-1.408 is applicable to the administration of the FEHBP contracts (see OPMR 16-3.12).

Subpart 16-1.5—Contingent Fee**§ 16-1.500 Scope of subpart.**

FPR 1-1.5 is applicable to the administration of FEHBP contracts.

Subpart 16-1.6—Debarred, Suspended, and Ineligible Carriers**§ 16-1.600 Scope of subpart.**

This subpart sets forth OPM's policy with regard to the debarment, suspension and ineligibility of carriers.

§ 16-1.601 Applicability.

OPM shall enforce the provisions of FPR 1-1.6 with respect to health insurance carriers and shall maintain a consolidated list of concerns to whom contracts will not be awarded.

Subpart 16-1.8—Reporting Possible Antitrust Violations**§ 16-1.801 General policy.**

Where proposals received in FEHBP procurements evidence violations of the antitrust laws, the procedures in FPR 1-1.8 may be used in referring such proposals to the Attorney General.

Subpart 16-1.10—Publicizing Procurement Actions**§ 16-1.1001 General policy.**

FPR 1-1.10 is applicable to the administration of FEHBP contracts. In addition, OPM will implement the following sections in the manner specified below.

§ 16-1.1002 Synopsis of proposed procurements.

At least 60 days prior to the beginning of the annual negotiation process for new FEHBP contracts, OPM shall publish a notice of its proposed procurement action in the Department of Commerce Synopsis. Interested carriers shall be directed to OPM for information concerning submission of applications for participation.

§ 16-1.1004 Synopsis of contract awards.

At the close of the negotiation period, OPM shall publish in the Department of Commerce Synopsis a list of all new carriers approved for participation in the FEHBP during the next contract year.

Subpart 16-1.12—Responsible Prospective Contractors**§ 16-1.1200 Scope of subpart.**

This subpart prescribes the policies concerning the responsibility of prospective carriers.

§ 16-1.1201 Applicability.

FPR Subpart 1-1.12 is applicable to the administration of FEHBP contracts. In addition, carriers must meet the requirements of 5 U.S.C. Chapter 66, and 5 CFR Part 600, and this Chapter 16.

Subpart 16-1.23—Environmental Protection**§ 16-1.2300 Scope of subpart.**

FPR subpart 1-1.23 is applicable to the administration of the FEHBP contracts.

PART 16-3—PROCUREMENT BY NEGOTIATION**Sec.****16-3.000 Scope of part.****Subpart 16.3-1—Use of Negotiation****16-3.100 Scope of subpart.****16-3.101 General requirements for negotiation.****16-3.102 Factors to be considered in negotiating contracts.****16-3.103 Dissemination of procurement information.****16-3.104 Disclosure of mistakes after award.****Subpart 16-3.2—Circumstances Permitting Negotiation****16-3.200 Scope of subpart.****16-3.210 Otherwise authorized by law.****Subpart 16-3.3—Determinations, Findings, and Authorities****16-3.301 General.****Subpart 16-3.4—Types of Contracts****16-3.4-3 Scope of subpart.****16-3.401 Types of contracts.**

Subpart 16-3.5—Price Negotiation Policies and Techniques**Sec.**

- 16-3.500 Scope of subpart.
- 16-3.501 Basic policy.
- 16-3.502 Preparation for negotiation.
- 16-3.503 Type of contract.
- 16-3.504 Conduct of negotiations.
- 16-3.505 Selection of offerors for negotiation and award.
- 16-3.506 Cost, profit, and price relationship.
- 16-3.507 Pricing techniques.
- 16-3.507-1 General.
- 16-3.507-2 Requirements for price or cost analysis.
- 16-3.507-3 Cost or pricing data.
- 16-3.507-4 Certificate of current cost or pricing data.
- 16-3.507-5 Defective cost or pricing data.
- 16-3.507-6 Refusal to provide cost or pricing data.
- 16-3.507-7 Unacceptable substitutes for pricing negotiations.
- 16-3.507-8 Evaluation and pricing of individual contracts.
- 16-3.507-9 Specified contingencies.
- 16-3.507-10 Subcontracting considerations in cost analysis.
- 16-3.507-11 Overhead rate consideration.
- 16-3.507-12 Sole source items.
- 16-3.507-99 Certificate of community rating.
- 16-3.508 Service charge.
- 16-3.509 Additional factors and considerations for determining the service charge.
- 16-3.510 Contract audit as a pricing aid.
- 16-3.511 Exchange of information.
- 16-3.512 Record of price negotiation.
- 16-3.513 Disposition of postaward audits.
- 16-3.514 Startup and other nonrecurring costs.
- 16-3.514 Contract clauses.
- 16-3.514-99 Price reduction for defective certificate of community rating.

Subpart 16-3.5—Subcontracting Policies and Procedures

- 16-3.503-2 Review and approval of subcontracts.
- 16-3.511-50 Subcontract clause.

Subpart 16-3.6—Cost Accounting Standards

- 16-3.1200 Scope of subpart.

Authority: 40 U.S.C. 486(c); 5 U.S.C. 8013.

§ 16-3.500 Scope of part.

This part prescribes policies and procedures which shall be observed by OPM in connection with procurement by negotiation under the Federal Employees Health Benefits Program (FEHBP).

Subpart 16-3.1—Use of Negotiation
§ 16-3.100 Scope of subpart.

This subpart deals with the nature and use of negotiation in the award of contracts under the Federal Employees Health Benefits Program (FEHBP).

§ 16-3.101 General requirements for negotiation.

FPR 1-3.101 (b) and (c) are applicable to the administration of the FEHBP contracts.

§ 16-3.102 Factors to be considered in negotiating contracts.

FPR 1-3.102 is applicable to the administration of the FEHBP contracts. Additional factors to be considered are provided in 5 CFR 590.501 and 590.502.

§ 16-3.103 Dissemination of procurement information.

FPR 1-3.103(a) is applicable to the administration of FEHBP contracts.

§ 16-3.104 Disclosure of mistakes after award.

FPR 1-3.104 is applicable to the administration of FEHBP contracts.

Subpart 16-3.3—Circumstances Permitting Negotiation**§ 16-3.200 Scope of subpart.**

FPR 1-3.200 is applicable to the administration of the FEHBP contracts.

§ 16-3.215 Other rules authorized by law.

(a) Pursuant to the authority of section 302(c)(15) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 232(c)(15)) purchases and contracts may be negotiated without formal advertising if "otherwise authorized by law." This provision preserves the authority to negotiate contracts conferred by other legislation.

(b) Contracts between OPM and health benefits carriers are contracted for "without regard to section 5 of title 41 or other statute requiring competitive bidding." [5 U.S.C. 8902] This statutory authority is construed to authorize negotiation pursuant to section 302(c)(15) of the Act and without regard to the advertising requirements of sections 302(c) and 303 of the Act (see FPR 1-3.215(c)).

Subpart 16-3.3—Determinations, Findings, and Authorities**§ 16-3.301 General.**

The following sections regarding determinations, findings, and authorities are applicable to the administration of the FEHBP contracts.

FPR 1-3.301

FPR 1-3.302(e)

FPR 1-3.305

FPR 1-3.306 (a), (b), and (d)

Subpart 16-3.4—Types of Contracts**§ 16-3.400 Scope of subpart.**

This subpart (a) describes and defines the types of contracts used in the Federal Employees Health Benefits

Program; (b) defines the areas of applicability in which each type of contract may be used appropriately and sets forth considerations and policies governing the choice of type of contract; and (c) imposes conditions on the use of certain of the available contract types.

§ 16-3.401 Type of Contracts.

(a) The Federal Employees Health Benefits Act provides that the Office of Personnel Management may contract with qualified carriers offering the following four types of health benefit plans: (1) Service Benefit Plan, (2) Indemnity Benefit Plan, (3) Employee Organization Plans, and (4) Comprehensive Medical Plans. [5 U.S.C. 8903] The Act provides that rates charged under these health benefit plans shall reasonably and equitably reflect the cost of the benefits provided. Rates determined for the first contract year of the Service Benefit Plan and the Indemnity Benefit Plan shall be continued for later contract terms, except that they may be readjusted for any later term, based upon past experience and benefit adjustments under the later contract. Two types of contracts are used in the FEHBP, experience rated, which is required by the Act for the Service Benefit Plan and Indemnity Benefit Plan, and community rated. Definitions and explanations of these two contract types are contained in Part 4, of this Chapter 16, "Special Types and Methods of Procurement."

(b) Other contract types or combination of types which will promote the best interest of the Government, subject to the restrictions in FPR 1-3.401(b) or in 5 U.S.C. 8902(l), may be negotiated if appropriate in the circumstance. To the extent that a contract type other than experience rated or community rated is selected, the relevant subsection of FPR Subpart 1-3.4 would apply.

Subpart 16-3.5—Price Negotiation Policies and Techniques**§ 16-3.500 Scope of subpart.**

FPR 1-3.500 is applicable to the administration of the FEHBP contracts. The renegotiation of rates or benefits in an FEHBP contract constitute a modification as intended by FPR 1-3.500.

§ 16-3.501 Basic policy.

FPR 1-3.501 is applicable to the administration of the FEHBP contracts and is supplemented as follows: The FEHBP contract pricing team specified in FPR 1-3.501-3(b)(1) may include an actuary.

§ 16-3.802 Preparation for negotiation.

The provisions of FPR 1-3.802 should be adapted to the FEHBP procedures and requirements as specified in Part 4 of this Chapter 16, "Special Types and Methods of Procurement" and 5 CFR 800.303.

§ 16-3.803 Type of contract.

FPR 1-3.803 is applicable to the administration of the FEHBP contracts.

§ 16-3.804 Conduct of negotiations.

FPR 1-3.804 is applicable to the administration of the FEHBP contracts.

§ 16-3.805 Selection of offerors for negotiation and award.

Application for approval of, and proposal of amendments to, health benefits plans should be made according to the procedures set out in 5 CFR Part 800.

§ 16-3.806 Cost, profit, and price relationship.

FPR 1-3.806 is applicable to the administration of the FEHBP contracts.

§ 16-3.807 Pricing techniques.**§ 16-3.807-1 General.**

FPR 1-3.807-1 (a) and (b)(2) are applicable to the administration of the FEHBP contracts.

§ 16-3.807-2 Requirements for price or cost analysis.

FPR 1-3.807-2 is applicable to the administration of FEHBP contracts.

§ 16-3.807-3 Cost or pricing data.

(a) FPR 1-3.807-3 is applicable to the administration of FEHBP contracts. To clarify implementation of the cost or pricing data requirement on the FEHBP, the following supplement information is provided:

(1) A community rated contract by definition (see OPMFR 16-4.152-1(a)) is the exception cited in FPR 1-3.807-3(b)(1)(i). Consequently, the contracting officer need not apply FPR 1-3.807-3(a) to carriers offering community rated plan contracts. The contracting officer may, however, require the carrier of a community rated plan to demonstrate that the community rate is in fact a community rate. In any event, the carrier shall be required to submit a certificate in accordance with OPMFR 16-3.807-50 certifying that the proposed rates are in fact a community rate as defined by OPMFR 16-4.151-2. Cost and pricing data may be required for any portion of the proposed rate that is not a part of the community rate if that portion is otherwise in accordance with the dollar criteria of FPR 1-3.807-3.

(2) Since cost or pricing data is not required for a community rated contract,

subcontract cost and pricing data as referred to in FPR 1-3.807-3(d)(1) need not be requested by the contracting officer.

(3) The contracting officer shall require carriers offering experience rated plan contracts to submit written cost or pricing data in accordance with FPR 1-3.807-3. Generally, each experience rated plan shall be required to submit, with its rate proposal, a projection of its operations for completion of the current year and for succeeding contract year(s), and to explain the derivation of each item in the projection. Data supplied by the carrier will be checked against reports filed by the carrier showing monthly paid claims incurred by quarter of each year. The data in these reports will also be verified by comparison to the carrier's annual accounting statement filed with OPM. The Office of Actuary will review the information filed by the carrier and compare the carrier's data with an independent projection developed by the actuary.

(4) A carrier offering an experience rated plan which is required to submit and certify cost or pricing data in accordance with FPR 1-3.807-3 shall be required along with its own submission to submit, or arrange for the submission of, cost or pricing data from its subcontractors as stated in FPR 1-3.807-3(d). See OPMFR 16-4.151-13 for definition of subcontractor.

(b) [Reserved.]

§ 16-3.807-4 Certificate of current cost or pricing data.

Where a certificate of cost or pricing data is required in accordance with FPR 1-3.807-3, a certificate in the form specified in FPR 1-3.807-4 shall be submitted as soon as practicable after agreement is reached on the contract subscription rates.

§ 16-3.807-5 Defective cost or pricing data.

FPR 1-3.807-5 is applicable to the administration of the FEHBP contracts.

§ 16-3.807-6 Refusal to provide cost or pricing data.

FPR 1-3.807-6 is applicable to the administration of the FEHBP contracts.

§ 16-3.807-7 Unacceptable substitutes for pricing negotiations.

FPR 1-3.807-7 is applicable to the administration of the FEHBP contracts.

§ 16-3.807-8 Evaluation and pricing of individual contracts.

FPR 1-3.807-8 is applicable to the administration of the FEHBP contracts. Application of this paragraph should not be confused with the readjustment of

rates on an experience rated contract. Surpluses or deficits on experience rated contracts should be considered in the adjustment of rates upon the renewal of contracts.

§ 16-3.807-9 Specified contingencies.

FPR 1-3.807-9 is applicable to the administration of the FEHBP contracts.

§ 16-3.807-10 Subcontracting considerations in cost analysis.

FPR 1-3.807-10 is applicable to the administration of the FEHBP contracts.

§ 16-3.807-11 Overhead rate consideration.

FPR 1-3.807-11 is applicable to the administration of the FEHBP contracts except that overhead or indirect costs are known as administrative expenses in the FEHBP.

§ 16-3.807-12 Sole source items.

FPR 1-3.807-12 is applicable to the administration of the FEHBP contracts.

§ 16-3.807-50 Certificate of community rating.

(a) Each carrier proposing a community rate shall submit the following certification with its proposal:

Certificate of Community Rating

This is to certify that the proposed subscription rate is a community rate in accordance with OPMFR 16-4.151-2.

(b) If it is subsequently found after agreement is reached on the subscription rate that the community rate is not a community rate as defined by OPMFR 16-4.151-2, the Government is entitled to a price reduction if the costs would have been lower had the contract been experience rated. The clause set forth in OPMFR 16-3.814-50 shall be inserted in each community rated contract.

§ 16-3.808 Service charge.

FEHBP carriers shall apply the principles set out in FPR Temporary Regulation 61, 46 FR 27645-27649, dated May 21, 1981 in the administration of FEHBP contracts.

§ 16-3.808-50 Additional factors and considerations for determining the service charge.

(a) In the construction of a subscription rate, the insurance industry includes a charge known as "retentions". Retentions represent the excess of premiums over benefit claim expenses and subscriber dividends. Retentions specifically include administrative expenses, a return to stockholders, if any, on their capital investments, and a contribution to reserves.

(b) In community rated contracts, the rate paid by the government is the same rate that is or will be charged on the effective date to the carrier's other policy holders selecting the same level of benefits. Consequently, a community-rated contract is assumed to include an adequate and competitive retention charge. Under FEHBP experience rated contracts, administrative expenses are determined on the basis of actual costs incurred and the balance of the retention charge is a negotiated sum. The part that is negotiated, i.e., return to stockholders and contributions to reserves, is not unlike "profit" or "fee". However, this negotiated sum in the FEHBP is known as the "service charge".

(c) The carrier may propose a service charge for a variety of reasons, such as, providing a return to stockholders and/or a contribution to reserves. However, the carrier's basis for determining a service charge may differ from OPM's basis for determining the reasonableness of a proposed service charge. In evaluating the reasonableness of a proposed service charge, the contracting officer shall only consider those factors which relate to the risk in or performance under the contract.

(d) The service charge is a negotiated amount which may or may not be proposed by an experience rated carrier in the FEHBP. If proposed, the contracting officer shall evaluate the reasonableness of the proposed service charge on the basis of the general factors identified in FPR 1-3.805-2 and the following factors which are directly pertinent to FEHBP experience rated contracts. These factors are solely for the purpose of analysis by the contracting officer and do not represent a basis for which a carrier may claim a service charge.

(1) *Underwriting risk.* The degree of risk assumed by the carrier should influence the amount of the service charge. Although the carrier underwrites the contract, that is, assumes the risk of loss in any one contract year, experience rating allows the loss in any one contract year to be recovered in future years. In effect, the contract is redetermined on the basis of actual costs incurred. Consequently, a loss on the contract can only result if the contract is terminated in a year in which the contract has a cumulative deficit or if the administrative cost ceiling is exceeded. In the first situation, the contract might provide for some additional indemnification. The amount of service charge for underwriting risk in this case should be minimal unless other

circumstances in a particular situation warrant greater consideration.

(2) *Conversions.* The FEHBP law provides that for an employee whose enrollment is ended, except by cancellation, the carrier must offer the employee the option to convert, without evidence of good health, to a nongroup contract providing health benefits. [5 U.S.C. 8902(g)] The potential conversions of persons with preexisting conditions represent an underwriting risk that is fully assumed by the carrier and the service charge should be influenced accordingly.

(3) *Extent of Government financial assistance.* Generally, the FEHBP contracts are assumed to be self-supporting. The premiums are paid to the carrier semi-monthly and are set so as to recover all projected costs, including a reserve for unpaid, but incurred claims. Consequently, premiums paid from the Federal Employees Health Benefits Fund generally finance the cost of the contract. Because of its underwriting responsibilities, however, the carrier may have to finance contract operations during periods of underwriting losses that deplete contract reserves until a time when premiums can be adjusted to restore them. Therefore, financing considerations should generally have a negative influence on the amount of service charge, except when, due to underwriting losses, the carrier must finance operations. The latter condition would have a positive influence on the service charge and can be recognized in the renewal of subscription rates when the condition actually exists.

(4) *Extent of the carrier's investment in facilities.* The carrier is expected to provide the facilities necessary to perform the contract either with equity or borrowed capital. Contract funds may not be used to purchase carrier assets. Consequently, the carrier's investment in facilities will be taken into consideration in evaluating the reasonableness of a proposed service charge if the cost of facilities capital is not otherwise recognized as an allowable cost in accordance with FPR 1-15.205-51. [See 46 FR 27045-27046 dated May 21, 1981.]

(5) *Carrier's performance.* The contracting officer may consider performance elements, such as, quality of service to subscribers, timeliness and accuracy in processing benefit claims, health care cost containment, and timeliness and accuracy of reports required by OPM. Where the carrier has consistently achieved excellent results in the foregoing areas, this performance merits a proportionately greater opportunity for service charges.

Conversely, a poor record in this regard may have a negative influence on the amount of the service charge.

(6) *Subcontracting.* Carriers provide health benefits plans for the FEHBP through a wide variety of organizational structures and contractual arrangements. In some instances, a significant portion of a health benefits plan is subcontracted so that only a minimum amount of responsibility or risk remains with the FEHBP carrier. The contracting officer shall ensure that in these instances there is no unreasonable pyramiding of the service charge.

(7) *Other considerations.* In renegotiating a service charge during contract renewals, the contracting officer may also consider any significant changes in the health plan's enrollment and changes in the consumer price index.

§ 1-3.806. Contract audit as a pricing aid.

Each health benefits plan is audited by the Audits Division, Compensation Group, OPM, on a periodic basis according to a schedule determined by the Audits Division in consultation with the contracting officer. The Audits Division prepares audit reports which are supplied to the contracting officer and the Office of the Actuary. The contracting officer utilizes these audit reports in evaluating the validity and accuracy of data submitted by the carriers, in conducting negotiations on rates proposed by carriers, and in evaluating the efficiency and effectiveness of carrier operations. The audit function as stated in FPR 1-3.806 is generally applicable to the administration of FEHBP contracts. However, due to the distinctive nature of the FEHBP contracts, the contracting officer need not make a specific request for an audit review of revised subscription rates on experience rated contract renewals. The evaluation of projections and trends in estimating health insurance subscription rates requires the expertise of an actuary. The subscription rate estimates are, consequently, reviewed by the Office of the Actuary. One component of the estimated subscription rate is the balance of the Special Reserve, that is, the contract surplus or deficit (see 5 CFR 890.201(8)). The Audits Division conducts periodic audits on an historical basis of carrier costs and thereby verifies the propriety of the reported Special Reserve balance. Although these reviews are not labeled as precontract audits, they amount to audits of the costs upon which future subscription rates are predicated. Therefore, in the

context of the FEHBP, a post-contract audit is the functional equivalent of the precontract audit required by FPR 1-3.803.

§ 16-3.810 Exchange of information.

FPR 1-3.810 is applicable to the administration of FEHBP contracts.

§ 16-3.811 Award of price negotiation.

FPR 1-3.811 is applicable to the administration of FEHBP contracts.

§ 16-3.812 Disposition of postaward audits.

FPR 1-3.812 is applicable to the administration of FEHBP contracts.

§ 16-3.813 Startup and other nonrecurring costs.

In order for a new carrier to provide benefits on the effective date of the FEHBP contract, a certain amount of start-up costs are necessary. For experience rated contracts, the contracting officer shall determine whether it is the carrier's intention to absorb these precontract costs or to recover them from the contract. When the carrier has conveyed its intention to absorb any portion of the start-up cost, there shall be an express contractual provision that such portion will not be charged to the contract.

§ 16-3.814 Contract clauses.

The appropriate contract clause specified in FPR 1-3.814 shall be included in each FEHBP contract.

§ 16-3.814-00 Price reduction for defective certificate of community rating.

The following clause shall be included in all contracts where the subscription rate was established on the basis of a community rate:

Price Reduction For Defective Certificate Of Community Rating

If it is determined that the subscription rate is not a community rate, as certified; and it is determined that on the basis of experience rating the cost to the Government would be lower, the price of the contract shall be reduced to that price which would have resulted had the contract been experience rated. In this event, the experience rated price shall be determined on the basis of actual costs incurred in accordance with 41 CFR 1-15.2, not to exceed the community rated price. Refunds due the Government shall be used to reduce future FEHBP subscription charges of the carrier.

Subpart 16-3.9—Subcontracting Policies and Procedures

§ 16-3.903-0 Review and approval of subcontracts.

FPR 1-2.903-3 is applicable to the administration of the FEHBP contracts. Under experience rated FEHBP

contracts, advance approval shall be required on all subcontracts or modifications to subcontracts which provide for the administrative services for the FEHBP Program, the adjudication of FEHBP benefits, and/or the underwriting of FEHBP benefits. The subcontract clause specified in OPMPR 16-3.903-00 shall be included in each experience rated contract.

§ 16-3.903-00 Subcontract clause.

Subcontracts

(a) The Contractor shall notify the Contracting Officer reasonably in advance of entering into any subcontract or subcontract modification if the subcontract provides for administrative services for the FEHBP Program, the adjudication of FEHBP benefits, and/or the underwriting of FEHBP benefits.

(b) The advance notification required by paragraph (a) above shall include:

(i) A description of the services to be called for by the subcontract;

(ii) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected;

(iii) The proposed subcontract price, together with the Contractor's cost or price analysis thereof;

(iv) The subcontractor's current, complete, and accurate cost or pricing data and Certificate of Current Cost or Pricing Data, when such data and certificates are required by other provisions of this contract to be obtained from the subcontractor;

(v) Identification of the type of subcontract to be used;

(vi) A memorandum of negotiation which sets forth the principal elements of the subcontract price negotiations. A copy of this memorandum shall be retained in the Contractor's file for the use of Government reviewing authorities. The memorandum shall be in sufficient detail to reflect the most significant considerations controlling the establishment of initial or revised prices. The memorandum should include an explanation of why cost or pricing data was, or was not, required and, if it was not required in the case of any price negotiation in excess of \$100,000, a statement of the basis for determining that the price resulted from or was based on adequate price competition, established catalog or market prices of commercial items sold in substantial quantities to the general public, or prices set by law or regulation. If cost or pricing data was submitted and a certificate of cost or pricing data was required, the memorandum shall reflect the extent to which reliance was not placed upon the actual cost or pricing data submitted and the extent to which this data was not used by the Contractor in determining the total price objective and in negotiating the final price. The memorandum shall also reflect the extent to which it was recognized in the negotiation that any cost or pricing data submitted by the subcontractor was not accurate, complete, or current; the action taken by the Contractor and the subcontractor as a result; and the effect, if any, of such defective data on the total price

negotiated. Where the total price negotiated differs significantly from the Contractor's total price objective, the memorandum shall explain this difference.

(vii) When incentives are used, the memorandum of negotiation shall contain an explanation of the incentive fee profit plan identifying each critical performance element, management decisions used to quantify each incentive element, reasons for incentives on particular performance characteristics, and a brief summary of trade-off possibilities considered as to cost, performance, and time; and

(viii) The Subcontractor's Disclosure Statement or Certificate relating to Cost Accounting Standards when such data are required by other provisions of this contract to be obtained from the subcontractor.

(c) The Contractor shall not enter into any subcontract for which advance notification to the Contracting Officer is required by this clause, without the prior written consent of the Contracting Officer. Provided, that the Contracting Officer in his discretion, may ratify in writing any subcontract. Such ratification shall constitute the consent of the Contracting Officer required by this paragraph.

(d) Consent by the Contracting Officer to any subcontract or any provisions thereof shall not be construed to be a determination of the acceptability of any subcontract price or of any amount paid under any subcontract or to relieve the Contractor of any responsibility for performing this contract, unless such approval or consent specifically provides otherwise.

(e) The Contractor agrees that no subcontract placed under this contract shall provide for payment on a cost-plus-a-percentage-of-cost basis.

Subpart 16-3.12—Cost Accounting Standard

§ 16-3.1200 Scope of subpart.

FPR 1-3.12 is applicable to the administration of FEHBP contracts and should be applied to each contract which meets the criteria therein. Applicability to FEHBP contracts is summarized as follows:

(a) Disclosure statements are not required under FEHBP contracts (FPR 1-3.1203-1)

(b) Cost Accounting Standards are applicable to FEHBP contracts which will usually meet the criteria for the modified contract clause (FPR 1-3.1204-2(b)) except that the following FEHBP contracts would be exempt from CAS coverage in accordance with FPR 1-3.1203-2(c):

- (1) Community rated contracts,
- (2) Small business concern contracts,
- (3) Contracts under \$300,000 unless the carrier is performing CAS covered contracts, in which case the FEHBP contract would be exempt if the amount of the contract is under \$100,000.

PART 16-4—SPECIAL TYPES AND METHODS OF PROCUREMENT**Subpart 16-4.1—Federal Employees Health Benefits Contracts**

Sec.

- 16-4.100 Scope and applicability of part.
- 16-4.101 Definition of terms.
- 16-4.101-1 Carrier.
- 16-4.101-2 Community rate.
- 16-4.101-3 Contractor.
- 16-4.101-4 Contract modification.
- 16-4.101-5 Contracting officer.
- 16-4.101-6 Director.
- 16-4.101-7 Experience rate.
- 16-4.101-8 FEHBP.
- 16-4.101-9 Government-wide plans.
- 16-4.101-10 Health benefits plan.
- 16-4.101-11 Negotiation.
- 16-4.101-12 OPM.
- 16-4.101-13 Subcontractor.
- 16-4.102 Policies and procedures.
- 16-4.102-1 Types of contracts.
- 16-4.102-2 Types of health plans.
- 16-4.102-3 Applications to participate in the FEHBP Program.
- 16-4.102-4 Proposals of existing FEHBP carriers.
- 16-4.102-5 Program requirements—information required of participating FEHBP plans.
- 16-4.102 Cost of benefits provided under experience rated contracts.

Authority: 40 U.S.C. 459(c); 5 U.S.C. 6013.

Subpart 16-4.1—Federal Employees Health Benefits Contracts**§ 16-4.100 Scope and applicability of part.**

This part describes the principal types of FEHBP contracts and sets forth policies and procedures used in connection with the procurement of health insurance coverage under the Federal Employees Health Benefits Program.

§ 16-4.101 Definition of terms.

For the purposes of this chapter, and unless otherwise indicated, the following terms have the meanings set forth in this subpart.

§ 16-4.101-1 Carrier.

"Carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization. (5 U.S.C. 6001(7))

§ 16-4.101-2 Community rate.

"Community rate" means a rate equivalent to that charged to all groups

of the carrier during the period of the contract for the same level of health benefits, regardless of the differences among the groups in actual or projected utilization of health care services.

§ 16-4.101-3 Contractor.

"Contractor" means carrier.

§ 16-4.101-4 Contract modification.

"Contract modification" means any written alteration in the requirements, rates, or other contract provisions of an existing contract, whether accomplished by unilateral action in accordance with a contract provision or by mutual action of the carrier and OPM.

§ 16-4.101-5 Contracting officer.

"Contracting officer" means an official designated to enter into or administer contracts and make related determinations and findings. The contracting officer for FEHBP contracts is the Assistant Director for Insurance Programs.

§ 16-4.101-6 Director.

"Director" means the Director, Office of Personnel Management.

§ 16-4.101-7 Experience rate.

"Experience rate" means a rate for a given group which is the product of that group's actual paid claims, administrative expenses, retentions, and estimated claims incurred but not reported, adjusted for benefit modifications, utilization trends, and trends in the economy.

§ 16-4.101-8 FEHBP.

"FEHBP" means the Federal Employees Health Benefits Program.

§ 16-4.101-9 Government-wide plans.

"Government-wide plans" means the service benefit plan and the indemnity benefit plan.

§ 16-4.101-10 Health benefits plan.

"Health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services. (5 U.S.C. 6001(6))

§ 16-4.101-11 Negotiation.

"Negotiation" means the procedure for making contracts without formal advertising.

§ 16-4.101-12 OPM.

"OPM" means the Office of Personnel Management.

§ 16-4.101-13 Subcontractor.

"Subcontractor" means one who performs for and takes from the prime contractor a specific part of the original requirements of the prime contract. In a contract for health insurance, original requirements comprise administrative services for the FEHBP Program, the adjudication of FEHBP benefits, and/or the underwriting of FEHBP benefits. In a contract for health services, as in a comprehensive plan group practice type arrangement, original requirements comprise administrative services for the FEHBP Program, the adjudication of FEHBP benefits, the underwriting of FEHBP benefits, and/or the provision of medical services through groups of physicians as defined by 5 U.S.C. 6003(4)(A).

§ 16-4.102 Policies and procedures.**§ 16-4.102-1 Types of contracts.**

Section 600, Title 5, United States Code, authorizes the Office of Personnel Management to enter into contracts with health benefits carriers to provide health benefits coverage for Federal employees and annuitants. Contracts between OPM and health benefits carriers are of two principle types, community rated and experience rated.

(a) *Community rated contract.* In a community rated contract:

(1) The subscription charge per subscriber is fixed for the term of the contract and is not subject to redetermination;

(2) The subscription rate is determined on the basis of a given level of benefits on a per person or per family basis which may vary with the number of persons in the family, but must be equivalent for all individuals and for all families of similar composition. The rate is determined without regard to the level of services required by any one subscriber group, but is sufficient to cover the cost of benefits delivered to all enrollees of the carrier purchasing the same level of benefits;

(3) The rate charged to Federal subscribers may differ somewhat from the community rate because: (i) certain additional benefits above the basic package may be provided to Federal subscribers (the costs of these benefits are referred to as "benefit loadings"); and (ii) minor adjustments from the community rate may be made in the rate charged to Federal subscribers to cover unique requirements of the Federal Employees Health Benefits Program (these adjustments are referred to as "standard loadings" and in some cases may be cost reductions (negative loadings)). Where, because of load-time

requirements in rate negotiations, an estimated community rate is used, and subsequently the actual community rate turns out to differ from the estimated rate, some readjustment may be made.

(b) *Experience rated contract.* (1) In an experience rated contract, the subscription charge per subscriber is fixed at the beginning of the contract term, but is subject to redetermination based upon actual cost incurred. [See OPMPR 16-4.153]

(2) If upon redetermination there is a surplus of the subscription charges collected by the carrier over the cost of providing the benefits, the surplus is carried forward to the next contract term as a positive balance in an account called the "special reserve." Conversely, if the cost of providing the benefits exceeds the subscription charges collected, the deficit is carried forward to the next contract term as a negative special reserve balance. The special reserve balance becomes a factor in determining subscription charges for the next contract term.

(3) Subscription charges held by the carrier which are in excess of the funds needed to discharge promptly the obligations incurred under the FEHBP contract must be invested and the income derived from the invested funds must be credited to the special reserve. [See 5 CFR 800.201(a)(9)]

§ 16-4.152-2 Types of health plans.

OPM contracts for the following health benefits plans:

- (a) Service Benefit Plan
- (b) Indemnity Benefit Plan
- (c) Employee Organization Plans
- (d) Comprehensive Medical Plans

A description of these plans is set out at 5 U.S.C. 8003.

§ 16-4.152-3 Applications to participate in the FEHBP Program.

By regulation (5 CFR 800.203), applications from carriers for participation in the FEHBP shall be accepted only for comprehensive medical plans and shall be submitted by March 31 preceding the contract year to which they refer. In a solicitation for new plans, OPM shall request detailed information of each carrier expressing interest in participating in the FEHBP. The Office of the Assistant Director for Insurance Programs and the Office of the Chief Actuary shall evaluate the information received as set out in 5 U.S.C. Chapter 86, 5 CFR Part 800, and this Chapter 16, and the contracting officer shall notify carriers meeting these requirements of their approval to participate in the FEHBP during the following contract year. Since each application is considered on its own

merits, there is no competition between offerors as is the case in other types of procurements. Negotiation for benefits and rates shall be completed no later than September 30 preceding the contract year to which they apply.

§ 16-4.153-4 Proposals of existing FEHBP carriers.

For plans which are under contract with OPM, a "call letter" shall be issued to the carrier on or about March 1 of each year soliciting benefits and rate proposals. Negotiation for new benefits shall begin on May 1, and all benefit and rate negotiations shall be completed no later than September 30 preceding the contract year to which they apply.

§ 16-4.153-5 Program requirements—information required of participating FEHBP carriers.

(a) At the times and in the form specified by OPM, participating carriers shall submit the following: enrollment data, utilization data, and a statement of program financial operations including the corresponding CPA statement on carrier operations.

(b) The Office of the Assistant Director for Insurance shall review the data to evaluate the management of financial and other resources. Information obtained in the analysis of these reports shall be used in determining the carrier's continuing ability to meet the statutory and regulatory requirements of 5 U.S.C. Chapter 86, 5 CFR Part 800, and the requirements of this Chapter 16.

§ 16-4.153 Cost of benefits provided under experience rated contracts.

In an experience rated contract, the cost of benefits provided represents the actual costs incurred under the contract. The total costs of the contract consist of the benefit payments made or accrued, plus administrative expenses incurred in adjudicating benefit claims and in the general operations of the carrier, plus the service charge and less investment income earned. In the absence of specific contract terms to the contrary, contract costs will be classified in accordance with the following criteria:

(a) *Benefits.* Benefit costs consist of payments made and liabilities incurred for covered health care services on the behalf of FEHBP subscribers, less any refunds, rebates, allowances or other credits received. If the FEHBP benefit costs must be determined on an indirect basis, the cost shall be determined in accordance with FPR 1-15.203.

(b) *Administrative expenses.* Administrative expenses consist of all allocable, allowable and reasonable expenses incurred in the adjudication of

subscriber benefit claims or incurred in the carrier's overall operation of the business. Unless otherwise stated in the contract, administrative expenses include, in part: all taxes including premium taxes, insurance and reinsurance premiums, medical consultants used in the adjudication process, concurrent care review when not billed by a health care provider and other forms of utilization review, the cost of maintaining eligibility files, and legal expenses incurred in the litigation of benefit payments. The amounts charged to the contract shall be actual, necessary expenses incurred in connection with administration of the contract, determined on an equitable and reasonable basis, with proper justification and accounting support, and in accordance with FPR 1-15.2. Administrative expenses exclude the cost of carrier personnel, equipment, and facilities directly used in the delivery of health care services and the expense of managing the FEHBP investment program.

(c) *Investment income.* The carrier is required to invest and reinvest all funds on hand, including any in the special reserve or any attributable to the reserve for incurred but unpaid claims, which are in excess of the funds needed to discharge promptly the obligations incurred under the contract. Investment income represents the amount earned by the carrier as a result of investing the FEHBP funds. The improper use of FEHBP contract funds does not relieve the carrier of the obligation of crediting the special reserve for investment income that would have been earned had it not been for the improper use of funds; consequently, the contracting officer shall insert the clause at OPMPR 16-7.503-6. The investment income earned may be offset with the expenses attributable to the investment program.

(d) *Service charge.* The service charge is a negotiated sum (see OPMPR 16-3.806).

(e) *Other items.* (1) *Mandatory statutory reserves.* Charges for mandatory statutory reserves are not allowable unless specifically provided for in the contract. When the term "mandatory statutory reserve" is specifically identified as an allowable contract charge without further definition or explanation, it means a requirement imposed by State law upon the carrier to set aside a specific amount or rate of funds into a restricted reserve that is separate and apart from all other reserves and surpluses of the carrier and may be used only in emergency situations with the specific approval of the State Insurance Commissioner. The

amount chargeable to the contract may not exceed an allocable portion of the amount actually set aside. If the statutory reserve is no longer required for the purpose for which it was created, and these funds become available for the general use of the carrier, a pro rata share based upon FEHBP's contribution to the total carrier's set aside shall be returned to the FEHBP in accordance with FPR 1-13.301-6.

(2) **Premium taxes.** When the term "premium taxes" is used in the contract without further definition or explanation, it means a tax imposed by State or local statutes upon the carrier's gross or net premiums received.

PART 16.7—CONTRACT CLAUSES

Subject 16-7.50—FEHBP Contract Clauses

- Sec.
- 16-7.500 Scope of subject.
- 16-7.502 Required clauses.
- 16-7.503-1 Definitions.
- 16-7.503-2 Disputes.
- 16-7.503-3 Equal opportunity.
- 16-7.503-4 Officials not to benefit.
- 16-7.503-5 Covenant against contingent fees.
- 16-7.503-6 Pricing of adjustments.
- 16-7.503-7 Employment of the handicapped.
- 16-7.503-8 Clean air and water.
- 16-7.503-9 Examination of records by the Contracting Officer.
- 16-7.503-10 Confidentiality of records.
- 16-7.503-11 Convict labor.
- 16-7.503-12 Listing of employment openings.
- 16-7.503-13 Preferences for U.S. flag air carriers.
- 16-7.503 Clauses to be used in experience rated contracts.
- 16-7.503-1 Price reduction for defective cost or pricing data.
- 16-7.503-2 Audit and records.
- 16-7.503-3 Subcontractor cost and pricing data.
- 16-7.503-4 Cost accounting standards.
- 16-7.503-5 Subcontracts.
- 16-7.503-6 Investment income.
- 16-7.504 Clauses to be used in community rated contracts.
- 16-7.504-1 Price reduction for defective certificates of community rating.
- 16-7.504-2 Audit and records.

Authority: 40 U.S.C. 486(c); 5 U.S.C. 5913.

Subject 16-7.50—FEHBP Contract Clauses

- § 16-7.500 Scope of subject.
- This subject sets forth contract clauses for use in all FEHBP contracts.
- § 16-7.502 Required clauses.
- The clauses set forth in this § 16-7.502 shall be attached, included in, or incorporated by reference in all FEHBP contracts.
- § 16-7.503-1 Definitions.
- Insert the clauses set forth in FPR 1-7.102-2.

§ 16-7.503-2 Disputes.

Insert the following clause as set forth in Temporary Regulation 56, 45 FR 35413, dated May 28, 1980:

Dispute Clause

(a) This contract is subject to the Contract Disputes Act of 1978 (Pub. L. 95-623).

(b) Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved in accordance with this clause.

(c)(i) As used herein, "claim" means a written demand or assertion by one of the parties seeking as a legal right, the payment of money, adjustment or interpretation of contract terms, or other relief, arising under or relating to this contract.

(ii) A voucher, invoice, or request for payment that is not in dispute when submitted is not a claim for the purposes of the Act. However, where such submission is subsequently not acted upon in a reasonable time, or disputed either as to liability or amount, it may be converted to a claim pursuant to the Act.

(iii) A claim by the contractor shall be made in writing and submitted to the Contracting Officer for decision. A claim by the Government against the contractor shall be subject to a decision by the Contracting Officer.

(d) For contractor claims of more than \$50,000 the contractor shall submit with the claim a certification that the claim is made in good faith; the supporting data are accurate and complete to the best of the contractor's knowledge and belief; and the amount requested accurately reflects the contract adjustment for which the contractor believes the Government is liable. The certification shall be executed by the contractor if an individual. When the contractor is not an individual, the certification shall be executed by a senior official in charge of the contractor's plan or location involved, or by having overall responsibility for the conduct of the contractor's affairs.

(e) For contractor claims of \$50,000 or less, the Contracting Officer must render a decision within 60 days. For contractor claims in excess of \$50,000 the Contracting Officer must decide the claim within 90 days or notify the contractor of the date when the decision will be made.

(f) The Contracting Officer's decision shall be final unless the contractor appeals or files a suit as provided in the Act.

(g) The authority of the Contracting Officer under the Act does not extend to claims or disputes which by statute or regulation other agencies are expressly authorized to decide.

(h) Interest on the amount found due on a contractor claim shall be paid from the date the claim is received by the Contracting Officer until the date of payment.

(i) Except as the parties may otherwise agree, pending final resolution of a claim by the contractor arising under the contract, the contractor shall proceed diligently with the performance of the contract in accordance with the Contracting Officer's decision.

§ 16-7.503-3 Equal opportunity.

Insert the clause set forth in FPR 1-12.803-2.

§ 16-7.503-4 Officials not to benefit.

Insert the clause set forth in FPR 1-7.102-17.

§ 16-7.503-5 Covenant against contingent fees.

Insert the clause set forth in FPR 1-1.503.

§ 16-7.503-6 Pricing of adjustments.

Insert the clause set forth in FPR 1-7.102-30.

§ 16-7.503-7 Employment of the handicapped.

Insert the clause set forth in FPR 60-741.4 (Temporary Regulation 38, 41 FR 22817, dated June 7, 1976) in all contracts and subcontracts of \$2,500 or more:

Employment of the Handicapped

(a) The contractor will not discriminate against any employee or applicant for employment because of physical or mental handicap in regard to any position for which the employee or applicant for employment is qualified. The Contractor agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified handicapped individuals without discrimination based upon their physical or mental handicap in all employment practices such as the following: employment, upgrading, promotion or transfer, recruitment or recruitment advertising; layoff or termination, rates of pay or other forms of compensation, and policies for training, including apprenticeship.

(b) The contractor agrees to comply with the rules, regulations, and relevant orders of the Secretary of Labor issued pursuant to the Rehabilitation Act of 1973, as amended.

(c) In the event of the contractor's noncompliance with the requirements of this clause, actions for noncompliance may be taken in accordance with the rules, regulations and relevant orders of the Secretary of Labor issued pursuant to the Act.

(d) The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices in a form to be prescribed by the Director, Office of Federal Contract Compliance Programs, Department of Labor, provided by or through the Contracting Officer. Such notices shall state the contractor's obligation under the law to take affirmative action to employ and advance in employment qualified handicapped employees and applicants for employment, and the rights of applicants and employees.

(e) The contractor will notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the contractor is bound by the terms of section 806 of the Act and is committed to take affirmative action to employ and advance in employment physically and mentally handicapped individuals.

(f) The contractor will include the provisions of this clause in every subcontract or purchase order of \$2,500 or more unless

exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to section 503 of the Act, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontractor or purchase order as the Director, Office of Federal Contract Compliance Programs, may direct to enforce such provisions, including action for noncompliance.

§ 16-7.503-8 Clean air and water.

Insert the clause prescribed by FPR 1-1.2302-2.

§ 16-7.503-9 Examination of records by the Comptroller General.

Insert the clause set forth in FPR 1-7.103-3.

§ 16-7.503-10 Confidentiality of records.

Insert the following clause in all FEHBP contracts.

Confidentiality of Records

The Carrier shall see the personal data on employees and annuitants which is provided it by Agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the Federal Register as a part of OPM's notice of systems of records.

The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers and family members confidential except as authorized by the patient or guardian and except as disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged criminal actions and to make audits of the contract and as necessary to carry out the coordination of benefits provisions of this contract.

§ 16-7.503-11 Convict labor.

Insert the clause set forth in FPR 1-1.2304.

§ 16-7.503-12 Listing of employment openings.

Insert the clause set forth in Temporary Regulation 30 (41 FR 33268-33267 dated August 9, 1976).

§ 16-7.503-13 Preference for U.S. flag air carriers.

Insert the clause set forth in FPR 1-1.323-2.

§ 16-7.503 Clauses to be used in experience rated contracts.

The clauses set forth in this 16-7.503 shall be attached, included in, or incorporated by reference in all experience rated contracts.

§ 16-7.503-1 Price reduction for defective cost or pricing data.

Insert the clause set forth in FPR 1-3.814-1(a).

§ 16-7.503-2 Audit and records.

Insert the clause set forth in FPR 1-3.814-2.

§ 16-7.503-3 Subcontractor cost and pricing data.

Insert the clause set forth in FPR 1-3.814-3.

§ 16-7.503-4 Cost accounting standards.

Insert the appropriate contract clause set forth in FPR 1-3.1204-2.

§ 16-7.503-5 Subcontracts.

Insert the clause set forth in FPR 16-3.803-50.

§ 16-7.503-6 Investment income.

Insert the following clause:

Investment Income

(a) The carrier shall invest and reinvest all FEHBP funds on hand which are in excess of the funds needed to promptly discharge the obligations incurred under this contract. The carrier shall seek to maximize investment income with due consideration to the safety and liquidity of investments.

(b) All investment income earned on FEHBP funds shall be credited to the Special Reserve on behalf of the FEHBP.

(c) Where the Contracting Officer concludes that the carrier has failed to comply with paragraph (a) above, the Contracting Officer may direct the carrier to credit the Special Reserve for investment income that would have been earned had it not been for the carrier's lack of compliance. Failure to comply with paragraph (a) includes failure to use FEHBP funds for allowable purpose and failure to place excess funds in income producing investments and accounts. If directed, the carrier shall credit the Special Reserve for income that would have been earned had it not been for its failure to comply with the terms of this contract. In calculating the amount of the credit due FEHBP, the annual rate of earnings reflected in the FEHBP Annual Accounting Statement shall be used.

§ 16-7.504 Clauses to be used in community rated contracts.

The clauses set forth in this § 16-7.504 shall be attached, included in, or incorporated by reference in all community rated contracts.

§ 16-7.504-1 Price reduction for defective certificate of community rating.

Insert the clause set forth in FPR 16-3.804-50.

§ 16-7.504-2 Audit and records.

The following clause shall be included in all community rated contracts:

Audit and Records

The Carrier agrees to permit the OPM to examine the records of the Carrier under this contract as may be necessary to carry out the purposes of the Act and Regulations. The Carrier agrees that it will preserve records relating to a contract period for five (5) years after the close of the contract period to which the records relate.

PART 16-8—TERMINATION OF CONTRACTS

Subpart 16-8.1—Definition of Terms

Sec.

16-8.101 Definition.

Subpart 16-8.2—General Principles Applicable to Withdrawal of Approval of Health Benefits Carriers and Settlement of FEHBP Contracts

16-8.250 Provisions for withdrawal of approval.

Subpart 16-8.3—Clauses

16-8.700 Applicability of subpart.

Authority: 40 U.S.C. 488(c); 5 U.S.C. 8013.

Subpart 16-8.1—Definition of Terms

§ 16-8.101 Definition.

For purposes of this part, "termination for convenience" means "withdrawal of approval."

Subpart 16-8.2—General Principles Applicable to Withdrawal of Approval of Health Benefits Carriers and Settlement of FEHBP Contracts

§ 16-8.250 Provisions for withdrawal of approval.

(a) Section 8002(e), title 5, United States Code, provides as follows: "Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title." Within the limitations of this statute, the provisions of FPR 1-8.3 and 1-8.3 shall be applied.

(b) Participating carriers which do not exhibit continuing ability to meet the requirements set out at § U.S.C. Chapter 80, 5 CFR Part 800, and this Chapter 16, shall be notified by the contracting officer of their deficiency. Within 10 days of the receipt of such notification, the nonconforming carrier shall provide OPM with evidence concerning the asserted deficiency. If the carrier fails to provide evidence satisfactory to OPM of its ability to meet its obligations under the contract, OPM shall require the carrier to present detailed plans, in a form prescribed by the OPM, for correcting the asserted deficiency. The carrier shall submit the plans within 20 days following receipt of notification. Pending submission or implementation of plans required under this section, the OPM may institute action as it deems necessary to protect the interests of enrollees, including, but not limited to: (1) suspending new enrollments under the contract; (2) advising enrollees of the asserted deficiencies and providing them an opportunity to transfer to another health plan. Failure to submit or to diligently implement plans which are

required under this section shall constitute sufficient grounds for withdrawal of the contract in accordance with the provisions for withdrawal of approval of health benefits plans set out at 5 CFR 800.205.

(c) Prior to withdrawal of the contract, the contracting officer shall seek to enter into an agreement with the carrier that provides for a procedure which includes, but is not limited to: (1) the settlement of benefit claims incurred during the period of the contract and the administrative costs incurred in settling claims; (2) the transfer of subscribers to another FEHBP carrier, and the administrative costs related to transferring such subscribers; and (3) the immediate disposition of excess funds in the special reserve of experience rated contracts.

Subpart 1-8.7—Clauses

§ 16-8.700 Applicability of subpart.

Termination for convenience of the government clauses set out in FPR 1-8.7 are not consistent with the provisions of 5 U.S.C. 8002(e) pertaining to the withdrawal of approval of FEHBP plans and, accordingly, have no practical application to the FEHBP contracts.

PART 16-11—FEDERAL, STATE, AND LOCAL TAXES

Subpart 16-11.50—Tax Treatment of FEHBP Contracts

Sec.

16-11.5000 Taxes in connection with the performance of community rated contracts.

16-11.5001 Taxes in connection with the performance of experience rated contracts.

Authority: 40 U.S.C. 480(c); 5 U.S.C. 8012.

Subpart 16-11.50—Tax Treatment of FEHBP Contracts

§ 16-11.5000 Taxes in connection with the performance of community rated contracts.

Taxes paid by community rated FEHBP plans are reflected in the community rate which is fixed for the term of the contract and is not subject to redetermination. Consequently, FPR 1-11 is not applicable to community rated contracts.

§ 16-11.5001 Taxes in connection with the performance of experience rated contracts.

Federal, state and local taxes on experience rated contracts present solely a question of allowability of costs and are treated in FPR 1-15.

PART 16-12—LABOR

Subpart 16-12.1—Basic Labor Policies

Sec.

16-12.100 General.

Subpart 16-12.3—Convict Labor

16-12.301 General.

16-12.304 Contract clauses.

Subpart 16-12.7—Fair Labor Standards Act of 1938

16-12.700 General.

Subpart 16-12.9—Equal Opportunity in Employment

16-12.901 General.

Subpart 16-12.10—Nondiscrimination Because of Age

16-12.1001 Policy.

Subpart 16-12.12—Williams-Steiger Occupational Safety and Health Act of 1970

16-12.1200 Policy.

Authority: 40 U.S.C. 480(c); 5 U.S.C. 8012.

Subpart 16-12.1—Basic Labor Policies

§ 16-12.100 General.

FPR Subpart 1-12.1 is applicable to the administration of the FEHBP contracts.

Subpart 16-12.3—Convict Labor

§ 16-12.301 General.

FPR Subpart 1-12.3 is applicable to the administration of the FEHBP contracts.

§ 16-12.304 Contract clauses.

The Convict Labor clause contained in FPR 1-12.304 shall be included in all FEHBP contracts.

Subpart 16-12.7—Fair Labor Standards Act of 1938

§ 16-12.700 General.

FPR Subpart 1-12.7 is applicable to the administration of the FEHBP contracts.

Subpart 16-12.9—Equal Opportunity in Employment

§ 16-12.901 General.

FPR subpart 1-12.9 is applicable to the administration of FEHBP contracts and all FEHBP contracts shall contain the Equal Opportunity clause contained in FPR 1-12.903-2.

Subpart 16-12.10—Nondiscrimination Because of Age

§ 16-12.1001 Policy.

OPM shall support the enforcement of Executive Order No. 11141 of February 12, 1964 which prescribes the public policy against discrimination on the basis of age by applying the provisions

of FPR 1-12.10 in the administration of the FEHBP contracts.

Subpart 16-12.12—Williams-Steiger Occupational Safety and Health Act of 1970

§ 16-12.1200 Policy.

OPM shall support the enforcement of the Williams-Steiger Occupational and Health Act of 1970 (29 U.S.C. 651-678) by complying with the provisions of FPR 1-12.12 in the administration of the FEHBP contracts.

PART 16-15—CONTRACT COST PRINCIPLES AND PROCEDURES

Sec.

16-15.000 Scope of part.

Subpart 16-15.1—Applicability

16-15.101 Scope of subpart.

Subpart 16-15.3—Contracts with FEHBP Carriers

16-15.300 Scope of subpart.

16-15.301 Basic considerations.

16-15.301-5 Credits.

16-15.308 Selected costs.

16-15.308-1 Advertising.

16-15.308-3 Bad debts.

16-15.308-6 Compensation for personal services.

Authority: 40 U.S.C. 480(c); 5 U.S.C. 8012.

§ 16-15.000 Scope of part.

This part contains the general cost principles and procedures for the negotiation and administration of FEHBP contracts.

Subpart 16-15.1—Applicability

§ 16-15.101 Scope of subpart.

FPR 1-15.1 is applicable to the administration of FEHBP contracts. In accordance with FPR 1-15.100, Part 1-15 will be used whenever cost analysis is performed and whenever a fixed-price type contract clause requires the determination or negotiation of costs. Consequently, costs for an experience rated contract shall be determined in accordance with FPR 1-15.2. The cost principles of FPR 1-15 are not applicable to that portion of a community rated contract that does not require cost analysis and/or the determination or negotiation of costs.

Subpart 16-15.3—Contracts with FEHBP Carriers

§ 16-15.300 Scope of subpart.

FPR 1-15.2 is applicable in its entirety to FEHBP contracts that require cost analysis and/or the determination or negotiation of costs. As the need arises, OPM will publish guidelines in this chapter 16 to be used for interpreting the application of FPR 1-15.2 to the FEHBP

contracts. These guidelines are not intended as a deviation from or a substitute for the FPR 1-15 unless specifically stated. The guidelines are as follows:

§ 16-15.201 Basic considerations.

In the absence of specific contract terms to the contrary, FEHBP costs will be classified and defined in accordance with OPMPR 16-4.153.

§ 16-15.201-6 Credits.

The provisions of 1-15.201-5 shall apply to income, rebates, allowances and other credits resulting from benefit payments which include, but are not limited to, coordination of benefit refunds, hospital year-end settlements, uncashed checks, utilization review refunds, and refunds attributable to litigation with subscribers or providers of health services.

§ 16-15.205 Selected costs.

§ 16-15.205-1 Advertising.

(a) In applying the provisions of FPR 1-15.205-1 to charges for media advertising costs of an asserted "educational" purpose, or for any other purpose except as provided for in OPMPR 16-15.205-1(b), the degree of prominence given to the carrier's name in the advertising copy will be a decisive factor in determining whether the message is intended to call favorable attention to the advertiser for the purpose of enhancing its overall image to sell its health plan.

(b) The cost of media messages which are directed at advising current FEHBP

subscribers on how to obtain benefits shall be an allowable expense within the meaning of FPR 1-15.205-1 since this service is directly related to performance of the FEHBP contract. If there is any question regarding the allowability of such a cost, the carrier may request an advance approval regarding the content and cost of the message.

§ 16-15.205-2 Bad debts.

The chargeability of erroneous benefit payments, overpayments and duplicate payments directly attributable to performance of the FEHBP contract shall be determined in accordance with the specific terms of the FEHBP contract. These erroneous benefit payments do not come within the intent of FPR 1-15.205-2.

§ 16-15.205-6 Compensation for personal services.

Overtime on an FEHBP contract would normally meet the condition specified in FPR 1-12.102-5; consequently, premiums for overtime, extra-pay shifts, and multi-shifts meeting the specified conditions shall be allowable without prior approval.

PART 16-20—RETENTION REQUIREMENTS FOR CONTRACTOR AND SUBCONTRACTOR RECORDS

Subpart 16-20.1—Purpose and Applicability

Sec. 16-20.102 Applicability.

Subpart 16-20.2—General Provisions

16-20.202 Other record retention requirements.

Authority: 40 U.S.C. 480(c); 5 U.S.C. 8013.

Subpart 16-20.1—Purpose and Applicability

§ 16-20.102 Applicability.

The contracting officer shall require FEHBP carriers to retain contract records as specified in OPMPR 16-20.202.

Subpart 16-20.2—General Provisions

§ 16-20.202 Other record retention requirements.

FEHBP carriers will be required to retain the materials described in FPR 1-3.814-2 (b) and (c) for 5 years after the end of the contract year to which they relate, except that claims benefits records shall be maintained for 3 years after the end of the contract year to which they relate.

PART 16-26—CONTRACT MODIFICATIONS

Subpart 16-26.4—Novation and Change of Name Agreements

Sec. 16-26.401 General.

Authority: 40 U.S.C. 480(c); 5 U.S.C. 8013.

Subpart 16-26.4—Novation and Change of Name Agreements

§ 16-26.401 General.

The provisions of FPR 1-26 are applicable to the administration of FEHBP contracts

(FPR Dec. 89-20912 Filed 7-9-81; 9:45 am)

ONLINE CODE 4326-01-01

August 13, 1981

Mr. Craig B. Pettibone
Director, Office of Pay and
Benefits Policy, Compensation Group
Office of Personnel Management
Room 4351
Washington, D.C. 20415

Dear Mr. Pettibone:

These comments are submitted on behalf of the undersigned carriers to the Office of Personnel Management (OPM) in response to the proposed rules appearing in 46 Fed. Reg. 35688 et. seq. (1981).

We remain in fundamental disagreement with the approach followed by OPM in designing these proposed procurement regulations for FEHBP's. In column 2 on page 35688 of the Federal Register, it is stated:

"The proposed regulations are intended to simply state in regulatory form what has long been our administrative practice in contract with health benefits carriers for health benefits plans. No substantive changes are intended in the way in which we administer health benefits programs."

We had hoped that these regulations would intend to seek to confirm in written regulatory form the long established policies and procedures for the FEHB programs, with the traditional deferences to insurance industry practices rather than setting forth new regulations that in effect legitimize for the auditors their past audit report controversies. These assurances were made in letters by Kevin J. Burns and Gary R. Nelson (dated June 31, 1981 and July 9, 1981, respectively) to James J. LaPenta, Director of the Mail Handlers Health Benefit Plan, that OPM did not intend to depart from traditional FEHB program deferences to insurance industry practice and that, "we do... not wish to impose any new documentation burdens on FEHB plans." These proposed rules, therefore, rather than simply seek to confirm in written regulatory form will lock in place the handling of administrative costs that has been the subject of much unnecessary dispute in the past, and legitimate controversy e.g., Return on Investment, ROI. One of the primary

purposes we carriers and our subcontractors responded to prior drafts of the proposed regulations and attended the meeting at OPM July 29, 1981 was to obtain agreement that these proposed regulations would be confirmatory of long established policies and procedures for the FEHB program with recognition to insurance industry practices.

A brief review of the history of FEHBP's current policies and procedures concerning the negotiation and administration of FEHBP contracts would more readily help identify which of the proposed regulations, in fact, confirm in written regulatory form the long-established policies and procedures or those that are new, over-regulate, ignore cost containment, and increase costs to the program.

On or about March 1 of each year, all carriers of ongoing FEHB plans receive a "call letter" from OPM soliciting benefits and rate proposals with maximum cost increases specified. The carriers then prepare and submit to OPM their new benefit proposals. These proposals contain not only improved benefits, but also may contain new benefits. Upon receipt of the carriers' proposals by OPM, the contracting officer, along with his professional staff, reviews the proposed benefits. Thereafter, the OPM and the carriers should engage in active negotiation with offers and counteroffers being exchanged until a benefits package is agreed upon by the parties. At this point, this procurement is similar to a DOD two-step negotiation. The carrier then submits a rate proposal for this negotiated benefits package. In preparing its rate proposal, the carrier will set forth all the usual formulae of an experienced rated plan for determining the benefit costs. To that will be added the projected management and administrative costs and service charge. Where the carrier is not self-insured, those costs which their subcontractors such as the underwriter or third party administrator have negotiated with the carrier will be included. This cost package, along with the necessary substantiation and documentation, is submitted to OPM in accordance with the instructions contained in the "call letter". After analysis by the contracting officer and his staff, negotiations are resumed and a rate is established for the benefits package for the contract term. Concurrently, there is also established the limitation of costs that the carrier can expend in administering this plan, as well as a dollar sum representing the service charge or risk charge. It also provides the carrier with authority to charge each enrollee for the cost of administering the program.

This contract negotiation is unique in federal government. There are in fact symbiotic contracts negotiated. One is the health benefits package providing the means by which federal employees can receive indemnification or prepaid health benefits. The other contract is the carrier's contract with the government that authorizes and enables the carrier to offer the sale of this health benefits package. This is the essence of how the FEHBP operates. Conceptually, it is different from usual FPR practices.

We must keep in mind that OPM by these negotiations of the FEHB plans and the subsequent offering of these plans by the carriers does not obligate the federal government. The OPM is not purchasing services to be rendered to the federal government. It is providing a means by which federal employees can receive either prepaid health benefits or be indemnified for expenses incurred in obtaining health services. The contract comes into existence between the federal employee and the carrier when the federal employee selects the plan. The federal employees are the purchasers and not the government. They select the plan and are required to pay for a substantial portion of it. The government contribution to the plan is not a purchase of services; rather, it is additional compensation to its employees in the form of a fringe benefit. The carriers do not supply any services to the federal government.

The Office of Personnel Management has endeavored to define experienced rated plans to be fixed price redetermination contracts. Once the rate has been established, the subscription charge is fixed for the contract period. After the end of the contract year, if there is a surplus of the subscription charges collected by the carrier over the costs of providing the benefits, that surplus is carried forward to the next contract period as a positive balance in an account called "the special reserve". Conversely, if the cost of providing the benefits exceeds the subscription charges, the deficit is carried forward to the next contract term as a negative "special reserve". The special reserve balance is a factor for determining subscription charge for the next contract term (OPMPR' 16.4.152-1(b)(2)). It is these features the OPM declares make this contract fixed price redetermination. True, the rate is fixed and true, there is a redetermination after the contract period; however, that is where the similarity with the fixed price redetermination contract set forth in the FPR's ends. FPR 1-3.404-7, "Retroactive Price Redetermination", is limited in application to research and development of under \$100,000.

The second contract that results from these negotiations is the contract between the carrier and the government whereby the carrier is authorized to provide and sell the health benefit coverage to federal employees. This contract sets forth the carriers' limitation of administrative expenses that may be charged enrollees as a percentage of subscription charges plus a service charge or risk charge. All of the carriers' subcontractors are likewise limited. There are no open-ended relationships; negotiations are at arms length.

The carrier's contract, which OPM calls "administrative cost plus", cannot be said to be a cost reimbursement plus fixed fee contract as set forth in the FPR's. As noted above, there is no obligation or commitment of any funds by the government.

Further, the FEHBP contracts assure the government that the carriers will continue to provide payments of benefits to federal employees. The FEHBP contract doesn't ever terminate nor does it contemplate termination. It uses a unique method of negotiated rates. FEHBP doesn't contemplate any further expansion of carriers except for the comprehensive plans. The contractors are a very limited and select group of carriers. The contract clauses set forth in the FPR's simply do not apply. These proposed procurement regulations are in effect putting the square peg in the round hole.

Therefore, for all of the above reasons, it is our contention that the FEHBP contracts are not the type of contracts that the FPR's were meant to scrutinize. The proposed procurement regulations far exceed Judge Harold Green's Order in the current court case (National Treasury Employees' Union v. Campbell 75-2173 D.C.C. September 18, 1981) "...that the FPR's is partially applicable to the health benefits contract. Both federal employees and organizations which contract with the government for such plans are entitled, in fairness and under Section 1.008, to the benefit of regulations which will inform them which portions are applicable and the extent to which Commission's policies deviate from the FPR's. "...the Commission need not promulgate entirely new implementing regulations which further clutter the maze of procurement regulations. . . ."

These proposed regulations include many sections that do not represent the established practices and policies. In fact, many represent disputed audit findings. The audit staff of OPM, when

it included these provocative sections, was attempting to legitimize the challenged audit findings. These proposed procurement regulations will increase costs and add little to the efficiency of the administration of the programs.

OPM and its predecessor, Civil Service Commission, had over 21 years in which to set forth applicable regulations. This they did not do. These ill advised proposed regulations in response to the Court's Order will only exacerbate the problems with audit staff. In fact, these proposed regulations will increase costs to the program by their complexity and overregulating the FEHBP's in direct conflict with the government's stated policy of reducing unnecessary regulation. They encourage a non-insurance approach resulting in increased costs to be borne by the federal employees. They do not provide for cost containment. The major thrust of these proposed regulations is focused on less than 10% of the costs, ignoring totally the other 90%. FEHBP programs are over 2 billion dollars per year. Finally, these regulations should be simplified by recognizing that good insurance industry accounting standards will prevail.

All of the undersigned carriers are concerned that these proposed regulations will unnecessarily increase the cost of health service for federal employees without contributing to efficiency of the program.

There is a need, as Judge Green pointed out, for the carriers and federal employees to know which of these federal procurement regulations are applicable and the extent to which they apply. All parties would benefit from codifying those past and long-established practices and recognizing certain well established insurance industry practices. These practices have led to effective administration of the FEHB program since its inception.

In the enclosure with this letter, we have responded specifically to each of the proposed OPMPR's following the order in which they were published in the Federal Register.

Very truly yours,

NATIONAL LEAGUE OF POSTMASTERS

By: Eugene B. Dalton
Eugene B. Dalton, President

NATIONAL RURAL LETTER CARRIERS' ASSOCIATION

By: John W. Emerigh
John W. Emerigh, Director of Insurance

NATIONAL FEDERATION OF FEDERAL EMPLOYEES

By: J. Gene Raymond
J. Gene Raymond, Executive Director

NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES

By: Marcia McQuillen
Marcia McQuillen, Director of Health Insurance

NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

By: M. G. "Mo" Twomey
M. G. "Mo" Twomey, Executive Vice President
For: Donald N. Ledbetter, President

NATIONAL ALLIANCE OF POSTAL AND FEDERAL
EMPLOYEES

By: Leon Henderson
Leon Henderson
For: Robert L. White, President

NATIONAL POST OFFICE MAIL HANDLERS, WATCHMEN,
MESSENGERS AND GROUP LEADERS DIVISION OF
THE LABORERS' INTERNATIONAL UNION OF NORTH
AMERICA, AFL-CIO

By: James J. LaPenta, Jr.
James J. LaPenta, Jr., Director,
Health Benefit Plan

Encl.

cc: Mr. Kevin Burns (w/encl.)

The following are the comments of the undersigned carriers to the notice of proposed rule making appearing in 46 Fed. Reg. 35688 et. seq. (1981) on a section by section basis.

§16-1.000 Scope of part.

This part should also include a new subpart, §16-1.011 providing that "FPR 16-1.011-1 and 16-1.011-2 shall apply to the administration of FEHBP contracts."

§16-1.101 Scope of subpart. (Regulation system).

No comment

§16-1.102 Purpose.

No comment

§16-1.103 Authority.

No comment

§16-104 Relationship of Chapter 16 to the FPR.

This section should be re-phrased to specifically state that all FPRs are not applicable to FEHBPs. The first paragraph states that "Chapter 16 provides guidance to the contracting officer, health benefit carriers....for implementing, supplementing and in certain instances deviating from the FPR." Subsection (d) does not clarify the situation by stating that "All parts of 41 CFR Chapter 1 which are "deemed" to have practical application....are specially dealt with..."

The court, on page 11 of its order dated September 10, 1980, states that

"Both federal employees and organizations which contract with the government for such plans are entitled, in fairness and under section 1.008, to the benefit of regulations which will inform them which portions are applicable and the extent to which Commission policies deviate from the FPR. The present situation where the Commission is able selectively to choose after the fact which regulations to apply or not to apply and to issue waivers is intolerable. Although the Commission need not promulgate entirely new implementing regulations which further to (sic) clutter the mass of procurement regulations, it is required at a minimum to specify which FPRs are applicable in the health benefit area and the extent to which they apply."

OPMRP 16-1.104 does not meet the criteria established by the court. It should be reworded so that OPM auditors do not unilaterally "deem" other FPRs to be applicable. The court order mandates more than mere guidelines to contracting officers.

\$16-1.106 Issuance.

No comment

§16-1.107-2 Numbering.

The term "at this time" should be deleted from the first sentence of subsection (d). That term infers that a particular FPR may have practical application at some time in the future but does not state how such an FPR will be implemented. If particular FPRs may become effective in the future, this paragraph should provide the method of implementation. If such a contingency is not contemplated, the term "at this time" should be deleted.

§16-1.107-3 Citation.

No comment

§16-1.107-4 Cross references.

No comment

§16-1.108 Implementation

No comment

§16-1.109-1 Description. (Deviation).

Paragraph (b) should be amended by adding to the last sentence: "except where necessary to conform to insurance industry practices and/or long established policies and procedures of the FEHBPs."

§16-1-109-2 Procedure.

No comment

§16-1.150 Use of designees.

This section is vague in that it leaves to the reader to decide whether there is, in fact, authority to delegate. Specifically delegated authority in subsequent OPMPRs should cite the specific source of the right to delegate rather than the statement "unless otherwise restricted by law or in the regulations in 5 CFR Part 890 or this Chapter 16". Also, see comments relating to OPMPR 16-1.401-1.

§16-1.250 Definitions.

No comment

§16-1.301-3 Negotiations.

This section needs clarification. The first sentence should read "Use of formal advertising in connection with the award of FEHBP contracts has been determined to be not feasible and not practicable." In the last sentence, the citation should be changed to FPR 1-3.215 in order to meet the citation requirements set forth in FPR 1-1.007-3 and 16-1.107-4.

§16-1.302-1 Who may contract.

No comment

\$16-1.302-3 Contracts between the Government and Government Employees or business concerns substantially owned or controlled by Government Employees.

No comment

\$16-1.303 Approval of signatures.

No comment

\$16-1.313 Records on contract actions.

No comment

\$16-1.318 Disputes.

This proposed regulation requires the insertion of a clause (see 16-7.502-2) which is in conflict with 5 U.S.C. §8912 which states: "The district courts of the United States shall have original jurisdiction, concurrent with the court of claims, of a civil action or claim against the United States founded on this chapter."

\$16-1.320 Subcontractor gift and kickbacks.

No comment except to the relevancy of the section.

\$16-1.323 Preference for U.S. Flag Air Carriers.

No comment except to the relevancy of the section.

\$16-1.341 Fraudulent claims.

No comment

\$16-1.341 Federal Procurement Data System.

The FPR referred to in this section is not set out in Chapter 1. The proposed section refers to a temporary regulation. There are no guidelines to follow when the temporary regulation expires.

\$16-1.400 Scope of subpart. (Procurement responsibility and authority).

- \$16-1.401-1, -2 - 1 Responsibility of the head of the agency.
 - 2 Responsibility of the Associate Director
 for Compensation

These sections define the responsibilities of the head of the agency and the responsibilities of the Associate Director for Compensation. There is no statutory basis cited authorizing the delegation of responsibility from the Director to the Associate Director for Compensation. While we have no objection to this type of delegation, per se, we are concerned that such delegation is proper so that the signatures ultimately appearing on any documents will be binding upon the government.

\$16-1.402 Responsibility of the Contracting Officer.

The comments relating to \$16-1.401-1 and 2 apply also to the delegation of authority in this paragraph.

\$16-1.403 Requirements to be met before entering into contracts. The provisions of this FPR are limitations on the right of the contracting officer to enter into contracts. This proposed regulation is taken verbatim from FPR 1-1.403. For the sake of consistency, the new regulations should state that "FPR 1-1.403 is applicable to the administration of FEHBP contracts." However, limitations on rights of contracting officers are subject to 5 U.S.C. 8901 et. seq.

\$16-1.404 Selection, designation, and termination of designation of Contracting Officer.

No comment

\$16-1.405 Ratification of unauthorized contract awards.

No comment except to the relevancy of the section.

\$16-1.406 Cost accounting standards

Sec.16-1.406 - Cost Accounting Standards

This section needs clarification to specify the applicability of cost accounting standards to carriers and to the subcontractors of those carriers which have chosen to sub-contract specific functions.

To attempt to provide one cost accounting method to apply to all carriers and all subcontractors does not take into account the

differences in either the types of FEHBPs or the cost accounting practices of the various subcontractors. The type of cost accounting should be a matter to be negotiated by the carriers for themselves and their subcontractors, if any.

Many carriers subcontract certain functions to insurance companies. The cost accounting standards embodied in the FPRs and followed by auditors in the past and proposed here for use in the future do not recognize insurance accounting practices. This proposed regulation was drafted prior to the meeting in the OPM auditorium on July 29, 1981 at which OPM gave assurances that insurance accounting practices would be recognized. Three of the carriers or underwriters present who addressed the issue of cost allocation (Blue Cross, Prudential and CNA) all pointed out that there were certain non-inventoriable costs that insurance accounting practice recognizes as properly chargeable to a Plan even though they are "non-inventoriable".

It was also pointed out that HMOs recover such costs as part of their community-rate. Prudential recovers that cost as a deduction declared under its dividend plan. For those carriers or underwriters which cannot recoup these costs as stated above, we think such costs should be recognized specifically in these regulations as properly chargeable to an agreed upon retention using authorized and competitive procurement techniques such as Established Market Price (see FPR 1-3.807-1(b)(2)). This lack

of recognition of insurance accounting practices has been the main cause of disputes between the auditors and the audited carriers and their underwriters. OPM should carry out its assured intent to defer to insurance industry practice and not impose any new documentation or audit on FEHBA Plans.

That this conflict exists is not surprising because the auditors are seeking to find conformance with the Cost Accounting Standards applicable to federal procurement in general. There has never been deference to insurance accounting practice and it is our understanding that these regulations will provide that deferral. Failure to do so will leave the auditors with no guidance except the Cost Accounting Standards that in some instances are clearly inapplicable and inappropriate for insurance. The auditors in such a situation can properly feel they have no choice but to deny charges for costs where neither party intended such denial. Clarification, as suggested above, should properly be included in these regulations.

\$16-1.500 Scope of subpart. (Contingent fees).

No comment except to the relevancy of the section.

\$16-1.600 Scope of subpart. (Debarred, Suspended, and Ineligible Carriers).

No comment

\$16-1.601 Applicability.

No comment

\$16-1.901 General Policy. (Reporting Possible Antitrust Violations).

No comment except to the relevancy of the section.

\$16-1.1001 General Policy. (Publicizing Procurement Actions).

No comment except to the relevancy of the section.

\$16-1.1003 Synopses of proposed procurements.

No comment except to the relevancy of the section.

\$16-1.1004 Synopses of contract awards.

No comment except to the relevancy of the section.

\$16-1.1200 Scope of subpart. (Responsible Prospective Contractors).

No comment

\$16-1.1201 (Applicability).

This section imposes requirements in addition to those contained in 5 U.S.C. Chapter 89 and 5 C.F.R. Part 890.

\$16-1.2300 Scope of subpart. (Environmental Protection).

No comment except to the relevancy of the section.

§16-3.000 Scope of part. (Procurement by Negotiation).

No comment

§16-3.100 Scope of subpart. (Use of Negotiation).

No comment

§16-3.101 General requirements for negotiation.

No comment

§16-3.102 Factors to be considered in negotiating contracts.

This section provides that FPR-3-102 is applicable to the administration of FEHBP contracts. It also includes references to 5 CFR 890.201 and 890.202 which define the minimum standards for health benefit plans and minimum standards for health benefit carriers. Emphasis should be given to the standards set forth in the 890.201 and 890.202. Many sections of 1-3.102 are clearly inapplicable to FEHBPs such as subsection (d) which requires consideration of delivery requirements, subsection (k) which requires consideration as to whether the prospective supplier requires expansion or conversion of plant facilities, subsection (l) which requires consideration as to whether prospective supplier is located in a surplus or scarce labor area, subsection (m) which requires consideration as to whether the prospective supplier will have an adequate supply of qualified labor, subsection (o) which requires consideration of the existing and potential workload of the prospective supplier,

subsection (p) which requires consideration of broadening the industrial base by the development of additional suppliers and subsection (q) which requires consideration of whether the contractor requires government furnished property, machine tools or facilities.

\$16-3.103 Disseminating of procurement information.

No comment except for the relevancy of the section.

\$16-3.104 Disclosure of mistakes after award.

No comment except to the relevancy of the section.

\$16-3.200 Scope of subpart. (Circumstances permitting negotiation).

No comment

\$16-3.215 Otherwise authorized by law.

No comment

\$16-3.301 General

This proposed regulation states that FPRs 1-3.301, 1-3.302(e), 1-3.305 and 1-3.308(a), (b) and (d) are applicable. FPR 1-3.301 includes a specific reference to the estimated cost of, and fees to be paid under cost plus a fixed fee contracts. FEHBP contracts are not cost plus a fixed fee contract, within the meaning and intent of the section. Reference to contracts with

foreign governments or agencies thereof should be deleted from FPR 1-3.301(a)(6). FPR 1-3.302(e) refers to FPR 1-3.807(b) which exempts the contracting officer from requiring the prospective contractor to submit written cost or pricing data where the contracting officer determines in writing that the price negotiated is based on (1) adequate price competition, (2) established catalog or market prices of commercial items sold in substantial quantities to the general public or (3) prices set by law or regulation. If the Established Market Price technique as authorized in FPR 1-3.807-3(b) as set forth above is adopted by OPM for those carriers who negotiate this technique for themselves or their subcontractors, then the cost or pricing data referred to in section 1-3.807-3 will not be necessary for those carriers or subcontractors.

The reference to FPR 1-3.808(a), (b), and (d) should be changed to FPR 1-3.808-1(a), (b), and (d).

§16-3.400 Scope of subpart. (Types of contracts).

This subpart purports to describe and define the types of contracts used in Federal Employee Health Benefit Programs. In fact, it describes the types of health benefit plans. The subpart should be retitled "Types of Health Benefit Plans." According to OPMPR 16-1.107-2, the numbering system used in chapter 16 is to conform to that of chapter 1. FPR 1-3.400 and the following define the types of contracts, e.g., fixed

price contracts, etc. The proposed types of contracts set out in OPMPR 16-3.400 are not types of contracts but types of benefit plans available under FEHBA, (5 U.S.C. 8903).

\$16-3.401 Types of contracts.

See comments relating to \$16-3.400.

\$16-3.800 Scope of subpart. (Price Negotiation Policies and techniques).

No comment

\$16-3.801 Basic policy.

This provision should be changed by stating "The FEHBP contract pricing team specified in FPR 1-3.801-3 (b) (1) shall include an actuary.

\$16-3.802 Preparation for negotiation.

FPR 1-3.802 does not recognize the long established policies and procedures of OPM and the FEHBPs in negotiations. The selection of sources is contained in 5 U.S.C. Chapter 89 and 5 C.F.R. Part 890.

\$16-3.803 Type of contract.

No comment.

\$16-3.804 Conduct of negotiations.

FPR 1-3.804 does not recognize the long established policies and procedures of OPM and FEHBPs in negotiations.

\$16-3.805 Selection of offerors for negotiation and award.

FPR 1-3.805 does not recognize the long established policies and procedures of OPM and FEHBPs in negotiations.

\$16-3.806 Cost, profit and price relationship.

This proposed regulation provides that FPR 1-3.806 is applicable to the administration of FEHBP contracts. We endorse the applicability of concepts set forth in FPR 1-3.806 particularly the recognition in paragraph (b) that the total price, not isolated costs are the primary consideration.

\$16-3.807-1 General (Pricing techniques).

This proposed regulation states that FPR 1-3.807-1(a) and (b) are applicable. Unfortunately, having made this statement the regulations do not otherwise utilize the applicability of those sections. For instance, a carrier may wish to utilize the Established Market Price procurement technique authorized in this section and negotiate the inclusion of certain direct and indirect costs to be included in the "retention" which is to be stated as a percentage of premium. Having included costs in a negotiated percentage, the rate will have been determined on a basis consistent with the lowest schedule of basic rates

generally charged new group health benefit plans issued to large employers (5 U.S.C. 8902 (i)). OPM and the carrier may determine the Established Market Price. OPM may thereafter audit the essential elements of a group insurance plan, namely Claim Payments, Claim Reserve Development Factors, Contingency Reserves and Inventoried Premium Taxes in lieu of the current practice of auditing particular costs because all costs, direct or indirect, would be included in the negotiated retention and expressed as a percentage of premium, the same as in plans issued to other large employers.

\$16-3.807-2 Requirements for price or cost analysis.

This section contains the general requirements for price or cost analysis. See comments relating to \$16-1.406.

\$16-3.807-3 Cost or pricing data.

See comments relating to 16-3.807-1 and -2.

\$16-3.807-4 Certificate of current cost or pricing data.

No comment.

\$16-3.807-5 Defective price or costing data.

See comments relating to 16-3.802-1 and -2.

\$16-3.807-6 Refusal to provide cost or pricing data.

See comments relating to 16-3.807-1 and -2.

\$16-3.807-7 Unacceptable substitutes for pricing negotiation.

See comments relating to \$16-3.807-1 and -2.

\$16-3.807-8 Evaluation and pricing of individual contracts.

See comments relating to \$16-3.807-1 and -2. FPR 1-3.807 does not recognize the long established policies and procedures of OPM and FEHBPs such as readjustments of rates on experience rated contracts.

\$16-3.807-9 Specified contingencies.

See comments relating to \$16-3-807-1 and -2.

\$16-3.807-10 Subcontracting considerations in cost analysis.

This section deals with cost analysis matters to be taken into consideration in subcontracting. In addition to the comments set forth in \$16-3.807-1 and -2, see also comments relating to \$16-3.808-50(6).

\$16-3.807-11 Overhead rate consideration.

See comment relating to \$16-3.807-1 and -2. In addition, the proposed regulation fails to recognize that "administrative costs" includes items other than overhead and indirect costs.

\$16-3.807-12 Sole source items.

Since there are 121 FEHBPs, FPR 1-3.807-12 is inapplicable by definition.

\$16-3.807-50 Certificate of community rating.

No comment

\$16-3.808 Service Charge.

This proposed regulation provides that the principles set out in temporary regulation 61, 46 F.R. 27645-27649 shall be applicable. There are no guidelines to follow in the event the temporary regulation terminates.

\$16-3.808-50 Additional Factors and Considerations for
Determining the Service Charge.

This proposed regulation discusses seven additional considerations for determining the service charge. Prior to discussing the additional factors, sub-sections (a) through (d) contain prefatory remarks upon which the additional considerations are based. Our comments relating to the prefatory remarks are as follows:

- (a) This sub-section discusses the charge known in the insurance industry as "retentions". It is stated that retentions represent the excess of premiums over benefit claim expenses and subscriber dividends and provides that retentions specifically include administrative expenses, a return to stockholders, if any, on their capital investments and a contribution to reserves. Although this description is acceptable as far it goes, it is incomplete. A retention is

generally expressed as a percentage of premium and is the amount, if any, retained after payment of claims to pay administrative and other expenses and to provide for a profit, if any. The definition stated in the proposed regulation does not take into account the possibility of insufficient funds to pay all claims. If that event, the loss is carried forward and there is no money to pay for expenses and to provide a profit but the carrier must continue to provide the contracted services.

- (b) This paragraph makes a distinction between community rated and experience rated contracts with respect to retention charges. A community rated contract is assumed to include an adequate and competitive retention charge.

It is stated that under an experienced rated contract administrative expenses are determined on the basis of "actual costs" incurred and the balance of the retention charges is a negotiated sum. This is an inaccurate description. Such costs may be indirect or direct. Costs in general, both indirect and direct, are included in the retention which is expressed as a percentage of premium. It is then stated that the negotiated sum is a profit or fee. While such an

amount may be called a profit, fee, service charge or other term, the primary purpose of the charge is to cover the underwriting risk assumed. The fact is that a carrier may lose money if the subscription charges are inadequate. The so called service charge is the amount charged for accepting the risk involved.

- (c) The comments with respect to the profit or fee apply to this section also. It is stated that "in evaluating the reasonableness of a proposed service charge, the contracting officer shall only consider those factors which relate to the risk in or the performance under the contract. This is consistent with sub-section (d) provided that OPM is considering the risk taken in underwriting a health benefit program. However, we do not understand the comment: "However, the carrier's basis for determining a service charge may differ from OPM's basis for determining the reasonableness of a proposed service charge." This comment needs clarification.
- (d) This section states that the contracting officer shall evaluate the reasonableness of the proposed service charge on the basis of the general factors identified in FPR 1-3.808-2 and the seven additional factors set forth in this proposed regulation. It should be noted

FPR 1-3.808-2 has been rescinded by Temporary Regulation 61 (see §16-3.808).

The following are the additional considerations:

1. Underwriting risk. OPM misses the point in some of the comments made under section (1). It states that the amount of service charge for underwriting risk in this case should be minimal unless other circumstances in a particular situation warrant greater consideration. There is the possibility each year that a contract may be terminated when it has an accumulated deficit or if the administrative cost ceiling is exceeded. While we do not object to the general discussion, we do object to the statement that the amount of service charge for underwriting risk is minimal.
2. Conversions. The proposed section states that the potential conversion of persons with pre-existing conditions represents an underwriting risk that is fully assumed by the carrier and the service charge should be influenced according. Unfortunately, there are no guidelines for the contracting officer to follow in determining how to evaluate the risk of conversion of persons with impaired health. Objective standards should be inserted or more definitive guidelines

provided for use by the contracting officer so that agreed upon risk charges for this aspect may be binding.

3. Although this section recognizes that a carrier may have to finance contract operations during a period of underwriting losses, it concludes that financing considerations should generally have a negative influence on the amount of service charge. The term "negative influence" is not clear and should be clarified. The carriers underwriting risk is covered under (1). It is not clear in reading this section whether OPM's position is that because premiums are paid semi-monthly the underwriting risk is somehow reduced. This is not true. If financing consideration refers to keeping the program running in a deficit year, OPM may state that this should be taken into consideration in the service charge. We tend to agree because financing considerations and underwriting risk are not synonymous.
4. Extent of the Carriers Investment in Facilities. This section states that the carriers investment in facilities will be taken into consideration in evaluating the reasonableness of a proposed service charge if the cost of facilities capital is not recognized as an allowable cost. This section is not clear. Investment in

facilities should be an allowable cost, not a factor in determining the service charge.

5. Carriers Performance. OPM is taking the position that the performance of the carrier such as quality of service, timeliness and accuracy in processing benefit claims may be taken into consideration in the service charge. This appears to be a "pay for performance" standard to which we have no objection. However, guidelines for performance should be provided.

6. Sub-contracting. This section recognizes that significant portions of a health benefit plan is sub-contracted and cautions the contracting officer to be sure that in these instances there is no unreasonable pyramiding of the service charge. The statement regarding pyramiding needs clarification. The test is the reasonableness of sub-contractor's price itself. The service charge of the sub-contractor should have no effect on the service charge of the prime contractor. The subcontractor's service charge must be evaluated as to its reasonableness with respect to the services performed by the sub-contractor and is not a part of the carrier's service charge. The carrier has the overall responsibility for the performance of the health benefit program. In managing the program, it is entitled

to a service fee. Likewise, those duties which it delegates or sub-contracts to underwriters or to claim administrators must be examined on the merits of those functions and the service charge of each sub-contractor determined on its own as to reasonableness.

(7) Other Consideration.

This section refers to changes in the consumer price index which is not relevant to service fee negotiations. Trends and indexes specific to health delivery costs and utilization rates are the proper factors to be considered in this context rather than the consumer price index.

\$16-3.809 Contract Audit as a Pricing Aid.

This proposed section discusses the role of the Audit Division, Compensation Group. It provides that the audit function as stated in FPR-1-3.809 is generally applicable to the administration of FEHBP contracts. Certain exceptions are set forth in the proposed regulations. However, the proposed regulation states that the "Audit Division conducts periodic audits on an historical basis of carrier costs and thereby verifies the propriety of the reported Special Reserve balance. Although these reviews are not labeled as pre-contract audits, they amount to audits of the costs upon which future subscription rates are predicated. Therefore, in the context of FEHBP, a

post-contract audit is the functional equivalent of the precontract audit required by FPR 1-3.809."

The audit function has been a continuing problem between carriers and auditors. The auditors have been concerned with particular costs and verification that they were, in fact, incurred rather than reviewing the total price of the product. As a pricing aid, post-audits have not been the functional equivalent of pre-contract audits because the audits are done many years later and are based upon costs which are no longer relevant due to such factors as inflation. In addition, the post-contract audits do not examine the price, only the costs. Also, the audit should be authorized by the contracting officer, not by the auditor himself.

\$16-3.810 Exchange of information.

No comment except to the relevancy of this section.

\$16-3.811 Record of price negotiation.

No comment

\$16-3.812 Disposition of post award audits.

No comment

\$16-3.813 Start up and other non-recurring costs.

No comment

\$16-3.814 Contract clauses.

FPR 3.814 is not applicable because of reasons set forth in the letter to which this document is attached. Only clauses mandated by public law or Executive Order such as employment of the handicapped should be required.

\$16-3.814-50 Price reduction for defective certificate of community rating.

No comment

\$16-3.903-2 Review and approval of subcontracts.

See comments relating to \$16-3.808-50.

\$16-3.903-50

See comments relating to \$16-3.808-50. This subsection is new and is inapplicable to FEHBP contracts, will increase costs unnecessarily and does not recognize long established practices and procedures of OPM and FEHBPs.

\$16-3.1200 Scope of subpart (Cost Accounting Standards)

See comments relating to \$16-1.406 which relates to cost accounting standards.

§ 16-4.150 Scope and Applicability of Part (Federal Employee
Health Benefit Contracts)

The title of the subpart is misleading in that the entire subpart deals with types of benefit plans rather than types of contracts.

§ 16-4.151 Definition of Terms

No comment

§ 16-4.151-1 Carrier

No comment

§ 16-4.151-2 Community Rate

No comment

§ 16-4.151-3 Contractor

No comment

§ 16-4.151-4 Contract Modification

No comment

§ 16-4.151-5 Contracting Officer

This section indicates that the contracting office for FEHBP contracts is the Assistant Director for Insurance Programs. As stated above, there is no statutory authority cited for designating anyone other than the Director as contracting officer. A statutory citation should be given so that carriers and auditors

may rely upon the signature of the Assistant Director for Insurance Programs as binding on the government.

§ 16-4.151-6 Director

No comment

§ 16-4.151-7 Experience rate

No comment

§ 16-4.151-8 FEHBP

No comment

§ 16-4.151-9 Government - Wide Plans

No comment

§ 16-4.151-10 Health Benefit Plans

No comment

§ 16-4.151-11 Negotiation

No comment

§ 16-4.151-12 OPM

No comment

§ 16-4.151-13 Subcontractor

No comment

§ 16-4.152-1 Types of Contracts

This proposed regulation should be retitled from "Types of Contracts" to "Types of Rates for FEHBP Contracts." It discusses community rated and the experience rated contracts in general terms in order to explain the basic differences between them.

§ 16-4.152-2 Types of Health Plans

No comment

§ 16-4.152-3 Applications to Participate in FEHBP Program

No comment

§ 16-4.152-4 Proposals of Existing FEHBP Carriers

No comment

§ 16-4.152-5 Program Requirements - Information Required of Participating FEHBP Carriers

No comment

§ 16-4.153 Cost of Benefits Provided under Experienced Rated Contracts

This section defines "actual cost" of experience rated contracts as consisting of:

(a) benefit payments

- (b) administrative expenses
- (c) investment income
- (d) service charge
- (e) other items

The "actual cost" is to be computed by adding the benefit payments made or incurred, administrative expenses, a service charge, and subtracting from the sum of those figures the investment income earned after offsetting the expenses attributable to the investment program.

The proposed OPMPR examines each of the above stated items separately.

(a) "Benefits". According to this sub-section, benefit costs consist of payments made and liabilities incurred for covered health care services on behalf of FEHBP subscribers less any refunds, rebates, allowances or other credits received. It further provides that if the benefit costs must be determined on an indirect basis, the cost will be determined in accordance with FPR 1-15.203. It is difficult to conceive how "benefit costs" as defined, may be incurred on an indirect basis. The type of costs mentioned in that particular FPR does not include "benefit costs".

(b) Administrative Expenses.

This section requires that expenses include taxes, reinsurance

premiums, etc. It requires that the amounts charged should be actual, necessary expenses incurred in connection with the administration of the contract determined on a equitable and reasonable basis with proper justification and accounting support in an accordance with FPR 1-15.2. See comments in response to § 16-7.503-6 and §16-1.406.

By requiring compliance with FPR 1-15.2, OPM fails to recognize that the carriers are non-profit organizations and many cost factors set forth in FPR 1-15.2 have no application.

(c) Investment Income.

This section requires a carrier to invest and reinvest all funds on hand including any in the special reserve in excess of the funds needed to discharge the obligations incurred under the contract. Investment income represents the amount earned by the carrier as the result of investing the funds. Improper use of funds does not relieve the carrier of the obligation of crediting the special reserve for investment income which would have been earned had it not been for improper use of the funds. Consequently, the contracting officer must insert the clause appearing in OPMPR 16-7.503-6. Refer to response to 16-7.503-6. Subsection (c) is somewhat confusing in that the last paragraph under sub-paragraph (b) states the expense of managing the FEHBP investment program is excluded. We understand this provision to relate solely to HMOs. The last sentence of this section states that the investment income earned may be offset with the

expenses attributable to the investment program. Allowing the cost of investment as an offset is objectionable in that the expense of investing should be an allowable cost not limited by a cap on the investment income for the period. In addition the proposed regulation, as stated, allows auditors to determine unilaterally, years after the fact, what is or is not proper use of funds. Past practice of the U.S. government is to charge interest from date of final disposition if a cost is disallowed, not ab initio.

(d) Service Charge.

This proposed regulation states only that the service charge is a negotiated sum and refers to OPMPR 16-3.808. Refer to our comments relating to OPMPR 16-3.808. Attention should be paid to those comments relating to sub-contractors (\$16-3.808-50(6)) and his price as a cost of the program. More importantly, administrative expenses (not including claim adjustment expenses) should be part of the retention along with the service charge and provided for in the regulations for those carriers which negotiate for use of the Established Market Price procurement technique. The service fee of the subcontractors, as is pointed out in our discussion of OPMPR 16-3.808-50(6), is not a part of the service fee charged by the prime contractor. This distinction is quite important.

(e) Other Items.

No comment

§ 16-7.500 Scope of Subpart(Contract clauses)

No comment

§ 16-7.502 Required clauses

Only appropriate clauses should be included in FEHBP contracts.

See comments relating to § 16-7.502-2.

§ 16-7.502-1 Definitions

No comment

§ 16-7.502-2 Disputes

See comments relating to §16-1.318

§ 16-7.502-3 Equal Opportunity

No comment

§ 16-7.502-4 Officials not to Benefit

No comment

§ 16-7.502-5 Covenant against Contingent Fees

No comment

§ 16-7.502-6 Pricing of Adjustments

See comments relating to § 16-1.406.

§ 16-7.502-7 Employment of the handicapped

No comment

§ 16-7.502-8 Clear Air and Water

This clause is completely irrelevant to FEHBPs.

§ 16-7.502-9 Examination of Records by the Controller General

No comment except to relevancy of the clause which is not a mandatory clause.

§ 16-7.502-10 Confidentiality of Records

This is a new requirement and may violate the federal privacy act.

§ 16-7.502-11 Convict Labor

No comment except to the relevancy of the section.

§ 16-7.502-12 Listing of Employment Openings

No comment except to the relevancy of the section.

§ 16-7.502-13 Preference for U.S. Flag Air Carriers

No comment except to the relevancy of the section.

§ 16-7.503 Clauses to be used in experienced rated contracts.

Comments will relate to the specific clauses which follow -

§ 16-7.503-1 through § 16-7.503-6.

§ 16-7.503-1 Price Reduction for Defective Cost or Pricing Data

This proposed regulation refers to FPR 1-3.814-1(a) relating to defective cost or pricing data or price adjustments related to defective cost or pricing data. See comments in response to 16-1.406. This proposed regulation contemplates a different type of procurement, is inapplicable to FEHBPs and ok, in fact, the Director of OPM has waived this requirement for the year 1980.

§ 16-7.503-2 Audit and Records

This proposed regulation requires the insertion of the clause set forth in FPR 1-3.814-2. See comments in response to 16-1.406.

§ 16-7.503-3 Subcontractors cost and pricing data

This provision requires the insertion of clause set forth in FPR 1-3.814-3. That provision pertains to subcontractor's cost and pricing data. See comments relating to 16-3.808-50(6), 16-4.153 and 16.1-406.

§ 16-7.503-4 Cost Accounting Standards

This proposed regulation requires the contract clause set forth in FPR 1-3.1204-2. The proposed clause would require contractors to follow cost accounting practices established or disclosed as required by regulations of the Cost Accounting Standards Board. See comments relating to § 16-1.406.

§ 16-7.503-5 Subcontracts

This proposed regulation requires the clause set forth in OPMPR 16-3.903-50. See comments made with respect to that proposed regulation.

§ 16-7.503-6 Investment Income

This proposed section requires the insertion of a clause relating to investment income.

Subsection (a) requires the carrier "to invest and reinvest all funds on hand which are in excess of the funds needed to promptly discharge the obligations incurred under the contract. The carrier shall seek to maximize investment income with due consideration to the safety and liquidity of the investment." The standard as set forth in the section is unsatisfactory. The contracting officer should be able to agree to a clause setting an investment rate of return or a formula for investment return. The present clause does not authorize him to do this and instead submits the vague concept of "maximizing investment income" that has been the subject of disputes in the past. The negotiating process must yield concrete definitions including those commonly used in the insurance industry. Use of broad terminology similar to that stated in this proposed regulation will continue disputes between carriers and OPM auditors on such an important matter as investment income. See also our comments relating to 16-4.153(c). The last sentence should specify which accounting statement is to be used.

§ 16-7.504 Clauses to be used in Community Rated Contracts

No comment

§ 16-7.504-1 Price Reduction for Defective Certificate of
Community Rating

No comment

§ 16-7.504-2 - Audit and Records

No comment

§ 16-8.101 Definition

No comment

§ 16-8.250 Provisions for Withdrawal of Approval

Delete reference to "this Chapter 16."

§ 16-8.700 Applicability of Subpart(Clauses)

No comment

§ 16-11.5000 Taxes in Connection with the Performance of the
Community Rated contracts

No comment

§ 16-11.5001 Taxes in Connection with the Performance of
Experience-Rated Contracts

This proposed regulation states that federal state and local
taxes on experience rated contracts presents solely the question

of allowability of costs and are treated in FPR 1-15 (which is contained in 41 CFR pages 645 through 722). The allowability of taxes must be stated specifically in the contract.

§ 16-12-100 General

No comment

§ 16-12.201 General (Convict Labor)

No comment

§ 16-12.204 Contract Clause Regarding Convict Labor

No comment

§ 16-12.700 General (Fair Labor Standards Act)

No comment

§ 16-12.801 General (Equal Opportunity in Employment)

No comment

§ 16-12.1001 Policy (Nondiscrimination because of age)

No comment

§ 16-12.1200 Policy (Williams-Steiger Occupational Safety and Health Act of 1970)

No comment

§ 16-15.000 Scope of Part (Contract Cost Principles and Procedures)

This proposed regulation states that it is concerned with general cost principles and procedures for negotiation and administration of FEHBP contracts. See comments relating to § 16-1.406.

§ 16-15.101 Scope of Subpart

See comments relating to § 16-1.406

§ 16-15.200 Scope of Subpart (Contracts with FEHBP carriers).
FPR 1-15.2 is inapplicable in that carriers are non-profit organizations, not commercial organizations.

§ 16-15.201 (Basic Consideration)

See comments relating to § 16-15.200.

§ 16-15.201.5

See comments relating to § 16-15.200. The matters discussed in this proposed must be the subject matter of a new OPMR.

§ 16-15.205-1 Advertising

The issue of advertising is confusing, and was the subject of considerable discussion at the meeting in the OPM auditorium July 29, 1981. We submit that the section on advertising should be redrafted recognizing the following principles: 1) Since the law requires annual open enrollment periods and since there is

competition between the respective carriers for enrollment of federal employees, advertisements directed to all federal employees (not just their current enrollees) should be an allowable expense. 2) A carrier's advice to its current FEHBP participants on how benefits may be obtained should be an allowable expense. 3) If an actual cost test is applied, there should be a "cap" on the amount of dollars allowable for 1) above, applied uniformly to all carriers utilizing a decremental scale to achieve parity between the largest carriers and those that are smaller.

§ 16-5.205-2 Bad Debts

See comments relating to § 16-15-200.

§ 16-15.205-6 Compensation for personal services.

See comments relating to 16-15-200.

§ 16-20.102 Applicability

No comment

§ 16-20.202 (Other Record Retention Requirements)

We do not understand this OPMPR because the FRP indicated does not make sense in this context.

§ 12-26.401 (Novation and Change of Name Agreements)

No comment

NATIONAL LEAGUE OF POSTMASTERS

By: Eugene B. Dalton
 Eugene B. Dalton, President

NATIONAL RURAL LETTER CARRIERS' ASSOCIATION

By: John W. Eneigh
 John W. Eneigh, Director of Insurance

NATIONAL FEDERATION OF FEDERAL EMPLOYEES

By: J. Gene Raymond
 J. Gene Raymond, Executive Director

NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES

By: Marcia McQuillen
 Marcia McQuillen, Director of Health Insurance

NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

By: M. G. "Mo" Twomey
 M. G. "Mo" Twomey, Executive Vice President
 For: Donald N. Ledbetter, President

NATIONAL ALLIANCE OF POSTAL AND FEDERAL
EMPLOYEES

By: *Leon Henderson*
Leon Henderson
For: Robert L. White, President

NATIONAL POST OFFICE MAIL HANDLERS, WATCHMEN,
MESSENGERS AND GROUP LEADERS DIVISION OF
THE LABORERS' INTERNATIONAL UNION OF NORTH
AMERICA, AFL-CIO

By: *James J. LaPenta Jr.*
James J. LaPenta, Jr., Director,
Health Benefit Plan

United States of America
Office of
Personnel Management

Washington, D.C. 20415

CR

Mr. Lonnie L. Johnson
National Director
National Post Office Mail Handlers,
Watchmen, Messengers and Group
Leaders Division of LIUNA, AFL-CIO
1221 - 19th Street, N.W.,
Washington, DC 20036

September 18, 1981

RECEIVED

SEP 21 1981

Dear Mr. Johnson:
This is to transmit to you a preliminary analysis of the Federal Employees Health Benefits Program prepared by Donald J. Devine, Director of the United States Office of Personnel Management. This analysis discusses items of immediate and important concern to FEHB carriers. We contacted you by telephone, or an official of your plan, on Friday, September 18, alerting you that the analysis was being mailed, asking your opinion about the 1981 FEHB open season, and bringing two or three key items of the analysis to your attention.

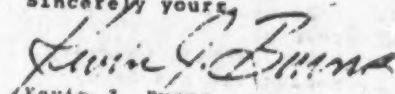
Although we believe you will find the entire analysis of interest, we want to bring your attention to three items in particular.

- The first item is Open Season. We asked you during our telephone call today whether you want to have an Open Season in 1981 and whether you believe it necessary to schedule at a different time, or to cancel it.
- The second concern is brought out in Item 9 on page 8 of the analysis. Director Devine has announced there is a shortfall of less than one month in the retirement fund appropriation needed to provide the Government's contribution for annuitants under the Program. Although we believe, with the assistance of Congress, this matter will be resolved to the satisfaction of all parties concerned, we have been directed to alert you to this problem.

- Third, as explained in Item 2 on page 6 of the analysis, those carriers required to submit equivalency proposals who have not yet done so, must submit them along with supporting documentation no later than September 25, 1981.

We will keep you informed of any decisions or developments that affect you and the FEHN Program.

Sincerely yours,



Kevin J. Burns,
Assistant Director for
Insurance Programs

cc. Mr. Martin Becker
Mr. James J. Lafenta, Jr.

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM:

PRELIMINARY ANALYSIS

DONALD J. DEVINE

DIRECTOR

United States Office of Personnel Management

Washington, D.C.

September 11, 1981

This paper reflects my preliminary analysis of problems that I have recently found in the methods heretofore employed by the United States Office of Personnel Management in planning and controlling the fiscal operations of the Federal Employees Health Benefits program (FEHB).

Last week I notified key Members of Congress and the White House of problems recently discovered in FEHB benefit projections as I reviewed the insurance carriers' estimates for next year's program. Likewise, the insurance carriers for FEHB were notified at an emergency meeting on August 21, 1981. As I reviewed these data it became obvious that to maintain the present level of health coverage would require an increase in insurance rates during 1982 of more than 30 percent in the six largest plans. Because the Federal Government pays 60 percent of the premiums for employees, the cost implications would be immense: continuing the current level of benefits would increase the Government's share of Fiscal Year 1982 program costs by \$500 million dollars above the amount in the President's budget.

Original budget projections assumed increased costs in 1982 of slightly over ten percent, which was in line with the experience of the previous few years. But it is now clear that, in addition to underestimating the effects

of inflation, OPM seriously underpriced most of the FEHB plans in 1980 and 1981. An artificial depression of premiums for a third consecutive year would only exacerbate problems which must be faced in the 1983 budget, as well as threaten the financial underpinnings of the FEHB program.

To protect the Government employee, it is necessary to keep premiums under control and to maintain benefits at an acceptable level. To protect the taxpayer, it is necessary to keep the Government contribution within budget constraints. The only solution is to pare benefits this year, but to do so only to the extent necessary to protect the budget and the financial integrity of the FEHB and the separate insurance plans.

I have now learned further that the appropriation previously voted by Congress for payment of the Government's share of annuitants' health benefits premiums for Fiscal Year 1981 will fall short of actual costs by the estimated amount of \$58,021,749. The total of the Government's share of the annual premium for annuitants in Fiscal Year 1981, which ends on September 30, 1981, will, by the closing date, reach approximately \$815 million. The unfunded share thus represents about 71 of the Government's obligation for the year.

Pursuant to 5 U.S.C. § 8902, OPM is authorized by Congress to contract on a continuing basis with qualified insurers for the provision of health benefits plans for Federal employees and annuitants. The authority conferred by Section 8902 provides for contracts which "shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party."

Under this authority, OPM has long maintained contracts for health benefits for employees and annuitants. As contemplated and authorized by Congress, these contracts are in force on a calendar-year basis, with annual automatic renewals.

While the Government's share of health premiums for active employees is paid by the several employing agencies, the Federal share of health benefit contributions for annuitants is paid from funds annually appropriated by Congress for that purpose, and maintained in a separate payment account established pursuant to 5 U.S.C. § 8906(g). The amount appropriated is based on estimates by OPM of premium rates, enrollment patterns, and numbers of annuitants who are expected to receive benefits during the fiscal year in question.

Estimates for Fiscal Year 1981, made in early 1980, were far too low. This error was seriously compounded by the failure of past OPM administrations to re-estimate the

need for a supplemental appropriation to the annuity account at the calendar year's end. It is only now that I have been able to discover these problems in OPM's administration of the FEHB program.

It appears that this problem has been a recurrent one at OPM. Erroneous estimates, for the same account and of comparable magnitude, have occurred in prior years. This points to a serious lack in internal control mechanisms within OPM to ensure proper estimates and to force re-adjustments at the time supplemental requests are due. Because it has been the intent of Congress to provide health benefits to retired Federal workers, however, Congress has never failed to vote necessary supplemental appropriations to correct such errors and to meet full costs of the Government's share of premiums.

I am deeply disturbed that apparent inadequacies in OPM's fiscal control systems have permitted this error to go so long without being foreseen, and have allowed similar errors to occur in several other recent years. Detection of the problem by built-in controls would have permitted timely communication to Congress of needs for supplemental appropriations in past Administrations. I will take steps to build these controls.

The Antideficiency Act, 5 U.S.C. § 665(a) provides, in pertinent part, that "No officer...of the United States shall make or authorize an expenditure from or create or authorize an obligation under any appropriation or fund in excess of the amount available therein; nor shall any such officer...involve the Government in any contract or other obligation, for the payment of money for any purpose, in advance of appropriations made for such purpose, unless such contract or obligation is authorized by law."

These insurance contracts are unquestionably obligations that are authorized by law, and they are, by their very nature--because they extend from calendar year to calendar year, renewable--entered into in advance of specific appropriations. But as a responsible officer of the United States, I cannot and will not countenance the risk of making "an expenditure from...any...fund in excess of the amount available therein..." even though authorized, in the absence of the necessary appropriations.

In consideration of all these factors, the following action shall be taken forthwith:

- (1) The Associate Director for Compensation will act firmly to conclude negotiations on 1982 contracts with the FEHB insurance carriers. The contractual arrangements will

be based upon equivalent benefit reductions for plans, as discussed previously with the carriers, particularly in the emergency meeting. To ensure that no individual and no plan will suffer disproportionately, these reduction discussions have focused upon increases in individual deductibles on hospitalization and supplemental benefits; reductions in supplemental co-insurance rates; placement of most non-hospital charges in the supplemental benefits program; and benefits reductions in the mental, abortion, dental, and other areas.

(2) The Associate Director for Compensation will notify all carriers who have not negotiated benefits and rates by September 18, 1981, that they will have five working days thereafter in which to make a final proposal. Should such a carrier's proposal not be forthcoming, or should it not provide a basis on which OPM can agree, OPM will decline to renew the carrier's contract.

(3) The Associate Director for Compensation will survey the FEHB carriers on the necessity to delay or cancel open season this year, and report those findings to me.

(4) The Associate Director for Compensation shall determine as accurately as possible the current census of employees, annuitants, and other eligibles covered by FEHB; the current backlog of unadjudicated retirement claims that

will generate retrospective and future FEHB obligations; the net number of persons in all categories who will be enrolled in FEHB at the close of Fiscal Year 1982; and the amount of unfunded liabilities in the Government's contribution for Fiscal Year 1981 to the annuitants' health benefits premium account.

(5) The Director of the Office of Internal Evaluation shall immediately investigate the annuitants' health benefits payment account, and the controls maintained thereon, and shall report his findings and conclusions to me with all deliberate speed.

(6) I shall request an independent audit of all trust funds and controls maintained by OPM, and a review of all accounting and auditing procedures, including recommendations for all modifications and reforms of such procedures as may be required or suggested by generally accepted accounting principles, generally recognized auditing standards, and sound, modern business practices.

(7) I shall request amendment of H.R. 4121, the appropriations bill for OPM and other agencies now pending in Congress, at page 29, line 15, as indicated by the underscoring as follows:

For payment of Government contributions with respect to retired employees, as authorized by chapter 89 of title 5, United States Code, and the Retired

Federal Employees Health Benefits Act (74 Stat. 849), as amended, \$792,754,000, to remain available until expended, and to be available for payments for the fiscal year ending September 30, 1981.

(6) I shall request inclusion of the following provision in the continuing resolution for OPM, if such a resolution is needed before October 1, 1981:

Funds made available by this Act for payment of Government contributions with respect to retired employees, as authorized by chapter 89 of title 5, United States Code, and the Retired Federal Employees Health Benefits Act, (74 Stat. 849), as amended, shall remain available until expended, and are available for payments for the fiscal year ending September 30, 1981.

(9) In the event that neither of the actions requested in paragraphs (7) and (8) above is adopted by Congress on or before September 30, 1981, then I will not authorize payment to the insurance carriers of funds for the Government's share of annuitants' FEHB premiums beyond the extent that such funds are actually available, until appropriate action is taken by Congress. In advance of such an eventuality, all affected entities, including the carriers, should be alerted to the problem. This report is a first notification of that situation. OPM will do its utmost to meet FEHB obligations as they mature. Payments to health care providers are not in immediate peril. But delays in remedial action

may result in disruption of the system and injury to FEHB beneficiaries. I have faith, however, that Congress will act and avoid any possible negative effects.

(10) The Associate Director for Compensation shall study possible legislative and contractual reforms of the FEHB system, including the questions of whether or not the Government's share of annuitants' premiums should be appropriated on a permanent indefinite basis; whether or not FEHB contracting should be shifted from a calendar year to a fiscal year schedule; and whether or not the payment of authorized premiums should be made expressly subject, legislatively or contractually, to the availability of appropriated funds.

There is no excuse for past failures to implement control systems which would have detected these problems at times that would have allowed more seasonable solutions, and would have permitted implementation of better across-the-board cost-containment measures. The Government, and particularly OPM, should set an example of the highest standards in professional management. I will not accept anything less. We will take whatever steps are necessary to achieve that goal.

STATEMENT TO FEHB INSURANCE PLANS

Gary R. Nelson
Associate Director for Compensation
Office of Personnel Management

August 21, 1981

Ladies and Gentlemen:

Thank you for meeting with us today on such short notice. Our negotiations with you on rates and benefits for the 1982 open season have taken an unexpected turn and created an immense problem for the FEHB program. We will discuss this problem with you and will ask your cooperation in moving ahead with the solution we propose.

Our call letter of last spring asked that you propose benefits for 1982 at about the same level as the benefits for this year, and benefit negotiations with you have followed our call letter very closely. At this time, we have tentative agreements with nearly all of you on the benefits to be offered in 1982.

Our problem stems from the premiums increases we (and you) are now projecting for 1982. Our budget projections for fiscal year 1982 assumed increased costs of slightly over 10 percent, which was generally consistent with our premium experience of the past few years. It is clear now that this seriously underestimates the inflation and utilization trend we now expect for 1982. Moreover, it is also clear that we seriously underpriced most of your plans in 1980 and 1981, producing deficiencies that must be corrected in 1982. Our analysis of your proposals reveals that the composite rates of the two largest plans in each category -- the big six -- would rise by over 30 percent for 1982. Budget outlays in fiscal year 1982 alone would be over \$500 million dollars larger than the figure included in President Reagan's 1982 budget.

You must recognize that we cannot allow increases of this magnitude to occur. We also believe that we cannot artificially depress premiums for 1982 because that would simply exacerbate the problem in 1983. Thus, we must seek some reduction in health benefits below those we have negotiated with you in the past few weeks. However, we do not think we can offset the full amount of the unexpected increase by this means.

The benefit reductions that George MacWhorter and I will introduce to you are designed to be as fair and equitable as possible, affecting all of the insurance plans in an even-handed way. We believe these reductions will spread the burden over as many enrollees as possible, so that no enrollees will lose a substantial portion of health benefits.

The three major changes we propose will apply to nearly all insurance plans:

1. To increase the deductible on supplemental benefits to \$200 per individual,
2. to reduce the coinsurance rate to 75 percent on supplemental benefits,
3. to place most non-hospital charges, such as out-patient tests, in the supplemental benefits program.

There are a few relatively minor changes that will only affect a few of you, and I will not mention these at this time. We also may need to make corresponding changes in the low option plans to assure that there are no inversions.

We recognize that this is an unprecedented development in the program, that it will impose unusual administrative burdens on the plans -- and on OPM -- and that it involves real burdens on employees. We believe the changes we are proposing are as fair and equitable as they can be under the circumstances.

We will meet with each of you individually to discuss how these proposals apply to your plan specifically. We will also proceed with our evaluation of your rate proposals. We still intend to hold open season as scheduled in November. And, this means that we must reach agreement on benefits in the next two weeks and on rates shortly thereafter. We ask your cooperation in this difficult and unpleasant task.

George MacWhorter will explain the benefit changes in greater detail, and he and I will attempt to answer any questions you may have.

August 31, 1981

Mr. George M. MacWhorter, Chief
Employee Organization Plans Division
Insurance Programs
Office of Personnel Management
P.O. Box 707
Washington, D.C. 20044

Dear Mr. MacWhorter:

At our meeting with you on August 25, 1981, we agreed to reconsider our proposal, subject to redetermination of all plans' benefits and rates. The following represents our tentative proposal of brochure rates and benefit revision:

1. Increase the calendar year maximum dental benefits from \$675.00 to \$750.00 per individual and from \$1,350.00 to \$1,500.00 per family

Bi-weekly Cost	Self	\$.01
	Self and Family	.02

2. Increase Diagnostic Laboratory and X-Ray Benefit from \$9.50 per RVS unit to \$10.50 per RVS unit

Bi-weekly Cost	Self	\$.13
	Self and Family	.30

3. Eliminate coverage of treatment for Alcoholism and Drug Abuse under the current in-hospital program. Add an Alcoholism and Drug Abuse benefit with coverage of up to 28 days per treatment session in any hospital or approved free-standing drug or alcoholism treatment facility with a maximum of 2 sessions per lifetime.

Bi-weekly Cost	Self	\$.11
	Self and Family	.27

Mr. George M. MacWhorter
 August 31, 1981
 Page 2

4. Increase Hospital Benefit maximum limit for mental and nervous conditions (exclusive of Alcoholism and Drug treatment) from \$2,500.00 to \$3,000.00 during any six-month period.

Bi-weekly	Self	\$.02
	Self and Family	.06

All of these rates have previously been justified in detail in a letter to Kevin J. Burns, Assistant Director of Insurance Programs. The Dental maximum increase represents CNA manual rates as there is no credible experience available under the current program to calculate a rate.

Sincerely,

James J. LaPenta, Jr.
 Director
 Mail Handlers Health Benefit Plan

Representative DERWINSKI. Thank you for your cooperation. I think this will be a valuable and positive record.

The hearing is adjourned.

[Whereupon, at 12:27 p.m., the hearing was concluded, to reconvene subject to the call of the Chair.]

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